

# **THE SURGICAL SYMPHYSIOTOMY *EX GRATIA* PAYMENT SCHEME**

**REPORT TO MINISTER FOR HEALTH**

**SIMON HARRIS TD**

**of**

**JUDGE MAUREEN HARDING CLARK**

**19<sup>th</sup> OCTOBER 2016**

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**Judge M H Clark**

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### OVERVIEW

1. Dr. Leo Varadkar TD, then Minister for Health, honoured me when in late August 2014 he asked me to sit as judicial assessor to a proposed scheme whereby those women who had undergone symphysiotomy would receive recompense on an ex gratia basis.
2. The Government decision to set up an ex gratia payment scheme was preceded by many years of activism by the women who had undergone surgical symphysiotomy between the 1940s and the 1970s. Two reports<sup>1</sup> were commissioned by the Government to establish the extent of these procedures and whether a compensation scheme should be established.
3. A great deal of adverse publicity surrounds the subject of symphysiotomy in Ireland. The Scheme was therefore premised on the widespread assumption that symphysiotomy was a surgical procedure which as a matter of near certainty, created lifelong suffering. It was generally asserted that Irish obstetricians were motivated by Catholic teaching on contraception rather than by obstetric need and that they were alone in the English speaking world in performing symphysiotomy during the 1940s until the late 1960s.
4. The terms of the Surgical Symphysiotomy Payment Scheme reflected those widespread perceptions and provided for payment once a surgical symphysiotomy was proved, no matter why the surgery was performed. Three levels of compensation were provided once an applicant established that she had undergone a surgical symphysiotomy between 1940 and 1990. Those dates had been identified by earlier research contained in the above reports commissioned by the Government. That research established the general parameters of the procedure. It had

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<sup>1</sup> Dr. Oonagh Walsh and Judge Yvonne Murphy

earlier been established that symphysiotomy was first carried out at the National Maternity Hospital at Holles Street (NMH) in Dublin in 1944 and that the last surgical symphysiotomy for disproportion was performed at the Medical Missionaries of Mary Hospital also known as the Hospital of Our Lady of Lourdes in Drogheda, Co. Louth in 1982<sup>2</sup>. Lobbying by survivor groups ensured that pubiotomy, a now outmoded obstetric procedure, would also be included in the Payment Scheme.

5. The 3 levels of compensation for those women who had undergone a surgical symphysiotomy procedure were :

- CATEGORY 1A: symphysiotomy only €50,000
- CATEGORY 1B: symphysiotomy with significant disability as defined in the Scheme €100,000
- CATEGORY 1C: a particular form of symphysiotomy, with or without significant disability €100,000 - €150,000
- Category P1 and P2: pubiotomy, with or without significant disability, €100,000 - €150,000

#### **CATEGORY 1A:**

6. It was correctly assumed that the procedure itself, which involves cutting through the fibrous cartilage of the pubic joint, caused considerable pain and discomfort during birth and in the peri-partum recovery period. It was assumed that some discomfort was present for up to 3 years. Every applicant who had undergone symphysiotomy was automatically entitled to payment of €50,000. If an applicant did not suffer any disability beyond

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<sup>2</sup> The last symphysiotomy for disproportion as opposed to for release of the after-coming head in breech delivery was performed in 1982.

the 3 year recovery period, it was open to her to apply under 1A. If she suffered disability beyond that period, then she claimed under 1B.

#### **CATEGORY 1B:**

7. The threshold for establishing symphysiotomy was strict but once the qualifying procedure was established, a generous interpretation of the balance of probabilities was applied in finding in favour of significant disability.
8. Significant disability was defined as medically verified physical symptoms or conditions directly attributable to symphysiotomy and which had lasted for more than three years. An applicant had to identify the claimed disability and provide some objective verification of the claimed condition. The threshold was not high. If significant disability was found, then the level of payment was €100,000. Being an ex gratia non-adversarial scheme, the findings were not exposed to the rigours of scientific examination. This should be borne in mind by medical personnel who view my findings.

#### **CATEGORY 1C:**

9. Any woman who had undergone an elective symphysiotomy<sup>3</sup> or undergone a combined operation of caesarean section *followed* immediately by symphysiotomy was automatically entitled to €100,000.
10. If significant disability following elective symphysiotomy or symphysiotomy described as '*on the way out*' was established, then the award was increased to €150,000.

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<sup>3</sup> one carried out in advance of labour



## **PUBIOTOMY:**

11. Finally, a special category P operated if pubiotomy was established. Pubiotomy is quite distinct from symphysiotomy. It involves the sawing through of the pubic bones<sup>4</sup> while symphysiotomy involves cutting through soft fibrous cartilage and does not involve bone or the use of a saw.
12. The sum of €100,000 was available for pubiotomy without disability and €150,000 for pubiotomy with disability.

## **COMMENCEMENT**

13. The Scheme was extensively advertised. The opening date for applications was the 10<sup>th</sup> November 2014 and the closing date 20 working days or 4 weeks later on the 5<sup>th</sup> December 2014. Almost 600 women applied for payment and claimed to have undergone a symphysiotomy / pubiotomy procedure.
14. The volume of applications was surprising but gratifying. It had been anticipated that the applicants would number fewer than 350. The advertising of the Scheme had clearly made the women who had undergone a symphysiotomy fully aware of the terms and purpose of the Scheme notwithstanding that for the most part, those women were elderly.
15. An unappreciated benefit of the process of assessment of such a volume of applications is that it provided an unparalleled opportunity to review medical records relating to the general health of post-symphysiotomy patients. For the first time, it was possible to evaluate the long-term effects of symphysiotomy on those patients. The findings made may be of interest to those obstetricians and orthopedic surgeons who have a genuine

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<sup>4</sup> with a surgical instrument known as the Gigli saw. This resembles a wire rather than a traditional saw.

interest in the long-term effects of symphysiotomy and in determining whether the procedure has any role in current obstetrics once they accept the caveats and limitations.

16. As independent Assessor, I determined that once symphysiotomy or pubiotomy<sup>5</sup> was established, a compassionate and generous view would be applied to the assessment of each claim. All objective evidence received or obtained was carefully considered and any doubt was applied in an applicant's favour. If an applicant identified a specific disability, her subsequent delivery records and her GP records were examined for evidence of any treatment or investigation capable of supporting the fact of that disability. The applicant's personal statement was reviewed and considered in the totality of the evidence. That is not to say that all statements and reports were accepted uncritically. Compassion did not overturn common sense when it was apparent that personal recollections were simply not corroborated by the contemporaneous medical records of the symphysiotomy delivery. In the same vein, subjective and partisan reports were excluded in favour of objective contemporaneous reports. Reports obtained specifically for the application and which merely repeated an applicant's claims were afforded little weight<sup>6</sup>. GP records which outlined symphysiotomy related conditions and referrals for x-ray were of primary importance. Medical advice was frequently sought and when claims could not be reconciled with established facts, the applicant was examined by an orthopedic surgeon or by a gynaecologist. In fact, some applicants were examined by several experts. Each application received an individual, careful and fair assessment.
17. Few applicants actually specifically identified their claimed disability. Very few medical records provided objective evidence of a named condition associated with symphysiotomy. Many hundreds of hours were therefore spent going through each applicant's medical records. This analysis

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<sup>5</sup> This report will deal with symphysiotomy only as pubiotomy was only established in 1 case out of 590 claims.

<sup>6</sup> More fully elaborated in the chapter on how assessments were made.

determined whether any condition could be identified which could be treated as a significant disability attributable to symphysiotomy. Unfortunately, huge amounts of records related solely to the conditions associated with old age such as cardiac disorders, hypertension, strokes and TIA (Transient Ischemic Attack), cancer, cataracts, hyperlipidemia, vertigo, thyroid complaints, diabetes and obesity.

## **BASIC FINDINGS**

18. The basic and relevant figures are:

- Almost 600 applications for payment were received. This includes applications received out of time.
- **185** out of almost 600 applicants were **unable to establish** their claim. All of these applicants were assisted in trying to establish their claims before being declared ineligible/not accepted into the Scheme.
- **Symphysiotomy was established** in **403** cases and **pubiotomy** in **1** case. **60** of those 403 cases involved symphysiotomy to release the after-coming head in breech deliveries and for shoulder dystocia.<sup>7</sup> This meant that 343 symphysiotomy procedures were carried out for reasons associated with disproportion. However, no distinction was made between any symphysiotomy.
- **399 applicants received awards.** The breakdown is:
  - 216 assessments at €50,000
  - 168 assessments at €100,000
  - 15 assessments at €150,000;
- **4 applicants died** before any offer was made;

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<sup>7</sup> A high percentage of symphysiotomy procedures carried out in 1970s and later were to release the after-coming head in breech delivery. These figures exclude the Lourdes Hospital.

- 1 applicant elected to reject the offer and to continue with her action through litigation;
  - 1 applicant died before the offer that was notified to her could be accepted.
19. **142** applicants of the above 183 cases where awards of €100,000 or €150,000 were made were assessed as having suffered **significant disability**.
20. **55** elective symphysiotomy or combined procedures of symphysiotomy *on the way out* were established and included in the gross figures above. **42** of the 183 applicants who received the higher award of €100,000 for elective/prophylactic or combined caesarean section with symphysiotomy did not suffer significant disability. The remaining 13 suffered significant disability.
21. **Pubiotomy** was frequently claimed but was established in only 1 case from Galway. Significant disability was established in that case. It was believed that a second case had been identified as a pubiotomy when we matched the case to a 1952 Annual Clinical Report to the Applicant. The pubiotomy was described as “*inadvertent*” while carrying out symphysiotomy. The applicant had been assessed as a patient who had undergone symphysiotomy as that is what was claimed and what appeared on the extract from the Birth Register. When radiology of her pelvis was obtained, it was reported that there was no evidence of any pubiotomy or attempted pubiotomy. The pubic symphysis had completely realigned with no evidence of the previous surgery. The use of the phrase inadvertent pubiotomy could not be squared with the radiology examined. **Pubiotomy was not established in any other claim.**

22. No general pattern of immediate or developmental injury was seen. The evidence did not confirm that symphysiotomy inevitably leads to lifelong pain or disability or those symphysiotomy patients aged in a manner which was different to those of non-symphysiotomy women. The majority of applicants who underwent symphysiotomy made a good recovery and went on to have normal pregnancies and deliveries and to lead a full life. Most applicants had at least 4 normal deliveries after the symphysiotomy<sup>8</sup>. A small number of applicants suffered from pelvic pain and a slightly larger group from urinary issues. Whether the conditions were associated with prolonged labour, the use of forceps, parity or the symphysiotomy procedure or a combination of all three was not possible at this remove to determine. It was noted that many symphysiotomy procedures were carried out after a 'failed forceps'.
23. It was noted the pubic joint had fully approximated and normalised in most cases. Radiology showed a completely normal pubic symphysis and normal sacroiliac joints indistinguishable from that of a woman who had not undergone symphysiotomy. The appearance of the pubic symphysis was abnormal in 80 cases with variable degrees of other musculo-skeletal conditions. 12 applicants demonstrated what were described as *grossly abnormal findings*<sup>9</sup>. The abnormal radiological findings included continuing diastasis (separation of the bones of the symphysis) of 15mm or more and included a small number of cases of severe sclerosis, fluid in the joint, large osteophytes, capsular hypertrophy, vertical misalignment or the presence of bone fragments<sup>10</sup>. Sometimes the wide diastasis was associated with sacroiliac joint arthropathy but in several instances, the sacroiliac joints were normal. There were very few cases of pelvic instability, that is, evidence of movement in the joint. For the purposes of the Scheme, if the appearance of the joint was abnormal, this was always taken as evidence of either inflammation or movement at the joint occurring in the immediate aftermath of the symphysiotomy procedure.

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<sup>8</sup> 2 applicants who had a symphysiotomy on their first delivery did not have any further pregnancies.

<sup>9</sup> These findings sometime had an iatrogenic element but were different from other radiological findings

<sup>10</sup> In some instances, these applicants had undergone treatment for pelvic cancers. All these conditions apart from wide diastasis and vertical misalignment in the pubic joint are found in the ageing population.

There were very few cases of hip degeneration at an inappropriate age and no documented cases of difficulty with walking after about 3 months.

24. 5 applicants had a documented history of incontinence associated with the symphysiotomy birth. They had suffered bladder / urethral damage or fistula at the time of symphysiotomy. The injury was identified within hours of the symphysiotomy and repaired at the first opportunity. All five applicants were thereafter predisposed to urinary tract infections and in one case, continuing incontinence.
25. The number of other possible iatrogenic injuries was small although the condition of some pubic joints on radiology was strongly suggestive of a want of expertise in the surgeon.
26. Pain and/or discomfort over the pubic joint during intimate relations in the first 12 months post symphysiotomy was a very common complaint. However, the vast majority of applicants became pregnant within a year of the symphysiotomy. Several applicants claimed that the symphysiotomy caused cessation of all sexual relations and the end of their reproduction. A small number claimed that their reluctance to engage in sexual intercourse led to marriage breakdown.
27. Each heading of finding of significant disability will be dealt with at length later in the report.
28. In 173 cases, neither the symphysiotomy nor pubiotomy claimed was established. The claimed procedure was not established in a further 12 late applications which were not received into the Scheme simply because it was evident that they would not be entitled to an award. The total of claims where symphysiotomy was not established was 185. In many cases, applicants had seen the word episiotomy on their records and had equated that with symphysiotomy. 23 other claims involved spontaneous symphysiotomy. The rest of the claims involved incorrect assumptions that

they had undergone symphysiotomy. Many applicants who did not undergo symphysiotomy provided statements of fairly harrowing memories of the operation and how their lives had been ruined, how they were unable to walk or take care of their babies, that they were incontinent, suffered prolapse of pelvic organs and had never recovered to this day. Much more concerning was that their claims of disability were supported by medical opinion. I believe that prolonged and exhausting labour (common until the concept of managed labour was advocated in the late 1960s by Dr. Kieran O'Driscoll at the NMH) and especially, if the delivery was by forceps was attributed to symphysiotomy. Such confabulation is understandable in the context of a difficult delivery many decades previously. Fear, pain, narcotic analgesia, exhaustion and dehydration can all contribute to confusion and memory blanks. It is therefore probable that hearing the testimony of others led many applicants who did not undergo symphysiotomy to acquire false memories<sup>11</sup> and to fill in the blanks. On several occasions, adult children advanced their belief that symphysiotomy had been performed on their mothers. Details of these cases will be found in the Chapter on **Ineligible Claims**.

### **A CATHOLIC PRACTICE OR AN IRISH PHENOMENON?**

29. Generally, symphysiotomy was an unnecessary procedure in the UK as caesarean section was carried out more readily and at a lower threshold than in Ireland. There was some evidence to contradict the belief that in the 1950s and 1960s, Ireland was alone in using symphysiotomy as a method of delivery<sup>12</sup>. We were unable to find evidence that symphysiotomy was performed in the major public hospitals in Liverpool, Leeds, Manchester, Glasgow or Belfast where significant communities of Irish

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<sup>11</sup> An extremely common memory was the hearing of the sound of a saw or seeing the doctor with a saw in his hands. No saw is used for symphysiotomy. The details contained in the personal statements of many applicants bore an uncanny resemblance to each other. That includes applicants who did not undergo symphysiotomy.

<sup>12</sup> Symphysiotomy continues to be a tool in the armoury of the obstetrician in the delivery of a trapped head in breech delivery or shoulder dystocia throughout the Western world.

Catholics lived.<sup>13</sup> There was on the other hand very strong evidence that from the 1930s, women in the above English cities routinely underwent tubal ligation after 2 caesarean sections or where the mother had a chronic medical condition such as asthma or cardiac disease. Contraception was also freely available in those cities. Tubal ligation was not so evident in the Royal Infirmary in Glasgow. There was some evidence that symphysiotomy was used in the UK in the 1940s<sup>14</sup> and in at least one hospital in Scotland in the 1950s<sup>15</sup>. Several very eminent professors of obstetrics who chaired meetings in Ireland in the 1940s and 1950s admitted that they had performed symphysiotomy. It continues to be used in emergency obstetric situations in the UK and in Ireland.

30. Very detailed and forensic examination of available contemporaneous medical records failed to find evidence of a religious as opposed to an obstetric reason when a symphysiotomy operation was performed. It was introduced to permanently enlarge a narrow pelvis and thus avoid unnecessary repeat caesarean section deliveries in a country where contraception was not countenanced by the Catholic population and was in any event illegal and unavailable. The evidence is that sterilization was not performed in any of the Dublin Maternity Hospitals at that time even though the procedure was not proscribed by law as with the case of contraception. The medical indication for symphysiotomy was always provided. This issue is addressed in later chapters.
31. The Annual Clinical Reports from the three maternity hospitals in Dublin – known as the Dublin School - were a valuable source for discerning attitudes to symphysiotomy and the reasons for its performance in the 25 or so years of the practice. When discussing symphysiotomy, the various Masters of the Dublin hospitals referred regularly to the fact that their

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<sup>13</sup> A reference to two symphysiotomies was found in the 1951 report at the Liverpool Women's Hospital but no description was given of the procedures nor details of the patients.

<sup>14</sup> Leading obstetricians Chasser Moir and Prof C Scott Russell who chaired the discussion meetings of obstetricians following publication of the Dublin Hospitals annual clinical reports (Transactions of the Royal Academy of Medicine in Ireland) stated that they had in fact themselves carried out symphysiotomies for specific conditions.

<sup>15</sup> DS Greig MD FRCOG *Symphysiotomy - A study based on 11 personal cases* Journal of Obstetrics and Gynaecology 1954



patients did not use contraception and that sterilization was considered unethical<sup>16</sup>. A full discussion of the **history** of the waxing and waning of the practice of symphysiotomy is found at the end of this report at Chapter 7. The source documents are bound together in Appendix II and III.

32. While evidence of religious motivation for reintroducing symphysiotomy into Irish obstetrics is found in the 1949 NMH Annual Clinical Report<sup>17</sup> and in a study on symphysiotomy written by A P Barry, Master of the NMH, it was absent from any other report although the issue of large families and no contraception was commonly raised during the annual discussions known as the Transactions Meetings. There appeared to be a high degree of support for Catholic teaching on contraception among those present and contributing to discussion.
33. The Annual Clinical Reports permit the conclusion that by the early 1950s, **all** the main maternity hospitals<sup>18</sup> in the State, regardless of their religious ethos or affiliations, were performing symphysiotomy as a cure for moderate disproportion. The assertions that this was a Catholic procedure rather than an Irish procedure were not corroborated by the Annual Clinical Reports or the contemporaneous records of discussion and debate at the annual meeting of obstetricians when the contents of the Dublin reports were examined.
34. It was observed that pubiotomy was not performed once symphysiotomy was introduced. The Rotunda Hospital performed its last pubiotomy in 1952 and its first symphysiotomy in 1951 or 1952. The NMH introduced symphysiotomy in 1943 and performed pubiotomy in the following year<sup>19</sup>. The Coombe Hospital commenced symphysiotomy in 1948. No reference to pubiotomy was made in any available clinical reports from 1944 to 1970 apart from references to accidental/inadvertent cutting of the pubic bone.

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<sup>16</sup> Which was not legally available and which was prohibited by their religion. See also *Textbook of Obstetrics* John F. Cunningham Fourth Ed. 1962 p. 431-432

<sup>17</sup> pg 8, 1949 NMH ACR

<sup>18</sup> Coombe, Rotunda, NMH, Drogheda, Cork and Galway

<sup>19</sup> A notation was found in the 1951 and 1952 annual clinical reports for the NMH which indicated that pubiotomy was carried out when the pubic joint could not be identified at symphysiotomy.

## THE DECLINE OF SYMPHYSIOTOMY

35. Symphysiotomy was a generally but infrequently practiced procedure in the 1950s and continued to be carried out fairly routinely but uncommonly for mild to moderate disproportion and obstructed labour until approximately the mid-1960s. Its frequency dramatically declined when an attitude change to symphysiotomy was evident from about 1967 and may coincide with papers published and an address made by Dr Kieran O'Driscoll on Active Management of Labour at that year's Transactions Meeting. The procedure was eventually phased out in all hospitals, albeit at a slower rate in the Lourdes in Drogheda. There was no evidence that symphysiotomy ever replaced or was intended to replace caesarean section. This subject is more particularly detailed in the Chapter on the history of symphysiotomy.
36. Many reasons have been suggested for the operation falling out of favour including that:
- nutrition and living conditions had improved generally and moderate contraction became less common;
  - routine ante-natal care identified mothers at risk well in advance of labour;
  - controlled and generous use of the oxytocics in managed labour of primigravids dramatically reduced the incidence of obstructed labour and the need for surgical intervention;
  - disproportion may have been over-diagnosed in the past;
  - new anaesthesia improved outcomes for babies delivered by caesarean section;
  - fear of repeat caesarean sections diminished;
  - changing attitudes on responsible parenthood led to smaller families;
  - the availability of the contraceptive pill.

37. It is for social historians to determine the reason or combination of reasons that led to the discontinuance of symphysiotomy. I am advised by Dr. McKenna that the major reason for the demise of symphysiotomy was the formidable influence of Kieran O'Driscoll on modern obstetrics and the availability of safe anaesthesia. The management of labour in first time mothers by the use of oxytocics meant that delivery by caesarean section became the method of treatment of cases of obstructed labour. Whatever the reason, examination of records suggests that 1967 saw the last symphysiotomy for disproportion in all three Cork Hospitals. The numbers performed in the Coombe fell to 2 in 1967, none in 1968 and 2 in 1969. In the NMH where symphysiotomy was reintroduced in 1943, the number fell to 3 in 1967, 2 in 1969 and 2 in 1972.<sup>20</sup> The last symphysiotomy for disproportion was performed in the Rotunda in 1966 when 8 such procedures were performed. Symphysiotomy continues to be a last resort procedure in emergency situations such as the trapped after-coming head in breech delivery and for shoulder dystocia. No major change was noted in the Lourdes hospital until 10 years later. Even there, the numbers were diminishing and the last record of symphysiotomy for disproportion / prolonged labour was in 1982<sup>21</sup>. 65 symphysiotomy procedures were performed there between 1970 and 1982 inclusive.
38. The position of the Roman Catholic Church on contraception, tubal ligation or vasectomy did not change in the late 1960s. In fact it hardened and now forbade the use of the pill or oral contraceptive. Since then Irish women have changed, the law has changed and the practice of obstetrics has reflected those changes.

### **WAS SYMPHYSIOTOMY A DELIBERATE ACT OF TORTURE<sup>22</sup>?**

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<sup>20</sup> Both of these procedures were carried out by Dr. Arthur Barry

<sup>21</sup> It is possible that one or two symphysiotomy procedures were carried out in 2003/2004 but we did not have proof of this as the clinical reports for that year were not available

<sup>22</sup> Submissions made by Survivors of Symphysiotomy to The United Nations Committee Against Torture.

39. Ireland of the 1940s was a very different place to the modern, clean, prosperous and mainly secular European State it is today. In 1943 when the first symphysiotomy was performed, the war was raging, rationing was in operation, malnutrition was common and TB was a major disease and a significant cause of early death. Living conditions for the poor in the slums of Dublin, Limerick and Cork were appalling. 30% of mothers giving birth at the Coombe and the Rotunda suffered from iron deficiency anaemia. Blood supplies were extremely expensive. The almoners' reports in the Dublin hospitals show that many mothers required assistance in the provision of free meals for themselves and clothing for their babies. More than 200 maternity deaths occurred every year in Ireland and even more babies were stillborn or died shortly after birth. Antibiotics were only becoming freely available. Ultrasound and vacuum extraction did not exist. However, the most relevant feature of Irish society then was that the laws and Constitution fully reflected the then strong religious practices and the conservative outlook of the general population<sup>23</sup>. The Constitution recognised the *special position* of the Roman Catholic Church. Being Irish and being Catholic were almost synonymous. The vast majority of the Catholic population accepted without question the strict application of Catholic teaching on birth control, marriage and sexuality. Few women occupied positions of power in the patriarchal society where most professions were male dominated, divorce was prohibited and married women were expected to stay at home and raise children. Shortly after the religious direction in a Papal Encyclical in 1930 that any form of birth control was a grave sin, the State introduced laws criminalising the sale or importation of any contraceptive. Ireland was a Catholic country where religion was happily embraced by the bulk of the population.
40. The influence of religion in medical practices and especially in reproduction has been extensively researched by Dr. Jacqueline Morrissey, a scholar in gender studies in her doctoral thesis: **An**

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<sup>23</sup> An example was the treatment of unmarried mothers and their children and the proliferation of shelters for these pregnant women. The Adoption Act was not passed into law until January 1953.

***examination of the relationship between the Catholic Church and the medical profession in Ireland.***<sup>24</sup>

41. The history of the practice of symphysiotomy in Ireland was fully examined by Professor Oonagh Walsh of Glasgow Caledonian University in her 2013 report on ***Symphysiotomy in Ireland 1944 to 1984***. Dr. Walsh, a medico-social historian with a special interest in female medical history, examined the reintroduction of symphysiotomy in Ireland in the 1940s and records its journey as an operation used to deliver mostly first-time mothers with a degree of pelvic disproportion until it went out of vogue (apart from exceptional circumstances) in the Dublin and Cork maternity hospitals by the late 1960s<sup>25</sup>.
42. Dr. Morrissey is critical of Dr. Alex Spain and Dr. Arthur Barry, both former Masters at the NMH for their open acceptance and support of Catholic views of contraception and sterilization and for their espousal of the symphysiotomy procedure as a method of avoiding demands by their patients for contraception or sterilisation. Both Dr. Morrissey and Dr. Walsh view the re-introduction of symphysiotomy in historical context of a compliant Catholic majority.
43. The involvement of religion in obstetrics and the possibility that symphysiotomy was an obstetric imperative to address particular problems for Irish Catholic mothers is clearly a matter of interest to social historians and for continuing discussion by scholars. Similarly, whether the particular obstetricians who advanced the case for symphysiotomy in the 1940s were primarily motivated by their religion or by their concern for their patients who shared the same religion and did not practice contraception, is a matter of conjecture. However, it seems unlikely that the obstetricians

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<sup>24</sup> This was referred to in the Lourdes Hospital Report

<sup>25</sup> Symphysiotomy continued to be performed in Lourdes Hospital in Drogheda into the 1980s. Among the claimants to the Scheme 15 cases of symphysiotomy were identified in other hospitals between 1970 and 1986.

at the Rotunda or the Erinville, both non-Catholic institutions, were motivated by Vatican dogma<sup>26</sup>.

44. From a practical standpoint, the vast majority of hospitals operated a Catholic ethos which reflected the practices of the large Catholic majority. Whether an obstetrician in Ireland of the 1940s and 1950s was a practicing catholic or a protestant or liberal agnostic, the reality for the patient was the same: contraception was not legally available. The possible consequences to the mother of repeat caesarean sections remained an obstetric dilemma for all. Tubal ligation or vasectomy were not available in any of the three Dublin maternity hospitals and the only practical and more extreme measure for preventing pregnancy was hysterectomy.
45. There is little validity or utility in applying British practices and their standards of the 1940s and 1950s to Irish obstetrics of the same period. The religious ethos in the UK was fundamentally different with different religious practices, smaller families, ready availability of contraception, male and female sterilisation and a well-funded health service.
46. Dr. J.K. Feeney, later Master of the Coombe Hospital and a prolific academic writer introduced symphysiotomy to the Coombe in 1948. He published a study of ***Caesarean Section in Dublin*** in the Irish Journal of Medical Science in December 1949. In that lengthy paper, he documented the rate of caesarean section in the Dublin Hospitals between 1932 and 1946 and examined each of the 61 maternal deaths associated with caesarean section with what he readily admitted was with wisdom after the event. He described the Coombe as *this ancient and venerable building [which] has received the women in travail from the most populous District in Dublin* and he described Dublin as *a city of 550,000 where the population was predominantly Catholic, where birth control is not practiced*

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<sup>26</sup> The Cork hospitals were reluctant at first to take up symphysiotomy. At the 1952 Transactions Prof. Kearney said "in Cork we were initially very much against symphysiotomy. Now we do it in the odd case. There is much to be said in its favour."

*and sterilisation is not carried out.* The Tables he appended to the study outline health problems prevalent at the time and show 282 cases of maternal morbidity(12.4%) and 61 maternal deaths out of 2273( 2.68%) caesarean sections performed in the previous 15 years.

47. While some of the maternal deaths in the earlier part of his look back were associated with uterine rupture following classical section, which by the late 1940s was rarely used, he nevertheless counselled against the reliance of lower segment caesarean section as an obstetrical panacea. *“It would seem that delivery by caesarean section is no guarantee of a high foetal survival rate; a 14% loss of life in new cases (in 1947) is most disturbing.”*
48. Dr. Feeney described conditions in the Coombe, an old, busy, overcrowded and under resourced maternity hospital in Dublin’s inner city catering to many poor, malnourished, anaemic and undersized women at the time<sup>27</sup>. When symphysiotomy was reintroduced<sup>28</sup>, it was to avoid repeat caesarean sections in cases where the first caesarean could have been avoided. As Dr. Feeney said in his review *“We do not question the necessity for or advisability of section in non-disproportion cases detailed in this paper [... ] We do however respectfully submit that the growing tendency to perform caesarean section for indications rather than major disproportion should be conscientiously reviewed from time to time in the light of maternal and foetal mortality rates, morbidity and invalidity.”*
49. The figures produced by Dr. Oonagh Walsh (and confirmed by our research) established that Dr. Feeney was correct. Caesarean section continued to be the operation of first choice in the case of essential disproportion and of course, for placental deficiencies and eclampsia. Even at the zenith of its popularity with Irish obstetricians, caesarean section which was carried out in very small numbers at the time always

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<sup>27</sup> The Clinical Reports referred frequently to women who were shorter than 4' 8"

<sup>28</sup> 70 years ago

exceeded symphysiotomy by many multiples. Symphysiotomy was performed in a very small percentage of deliveries<sup>29</sup>.

50. The Annual Clinical Reports prepared by the Masters of the Dublin hospitals of the 1940s and 50s show that their primary preoccupation was to reduce maternal mortality and to improve outcomes for babies. The strong correlation between obstructed labour and dead and damaged babies was well recognised and any procedure which improved outcomes for mothers and especially their babies was likely to be adopted. In the UK the route was caesarean section and sterilisation after 1 or 2 repeat sections. In Ireland, a very much more conservative approach to caesarean section was taken. Neither applicants' records nor narratives contained in the Clinical Reports lend support to the view that symphysiotomy was anything other than an attempt to improve maternal and fetal outcomes. Its primary purpose was to avoid caesarean section by permanently enlarging a marginally small pelvis. Married women were expected to have several children as families at that time were large by the today's norms. Having 5 or more children was normal and the Dublin School was famous for the frequent delivery of women considered to be *grand multips*.<sup>30</sup> There was no evidence of any kind to suggest intention to inflict pain. The prevailing philosophy in the Dublin maternity Hospitals was plainly conservative in relation to caesarean section and was repugnant to sterilisation.
51. The progress and development of attitudes to symphysiotomy during the period of the 1940s to 1970s is found in the historical chapter on symphysiotomy and in Appendix II and III.
52. Tables of symphysiotomy numbers are provided.

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<sup>29</sup> Approximately 60 per 100,000 births or 0.05% Walsh Report. During the same period the cesarean section rate doubled from 2,000 per 100,000 births to 4,000 in 1984.

<sup>30</sup> Women giving birth to their sixth baby or higher. Records showed that many mothers gave birth to more than 10 children.



53. The Cork hospitals - St Finbarr's, the Erinville and the Bons Secours - where symphysiotomy was also performed did not publish the equivalent of the Dublin or Drogheda Clinical Reports at the relevant times. Symphysiotomy was not itemised in the limited reports and the reasons for such procedure in the Cork hospitals cannot therefore be reviewed apart from information gleaned from discussions at the Transaction Meetings. See Prof. W Kearney's comments at the Transaction Meeting in 1953 and 1957. Disproportion and failed forceps were the most common reasons recorded for symphysiotomy in the Birth Register extracts from the Cork hospitals.
54. Dublin Clinical Reports habitually outline each hospital's activity where the Master described the achievements and major problems encountered in his particular hospital in that year. Adverse outcomes/events and morbidities were identified and described and suggestions made to prevent recurrence. The departing Master always presented a review of his mastership in his valedictory report. The new Master generally outlined his policy in his first report where he described any proposed changes in practice. A change of Master could see a change in practice. Caesarean section rates were always discussed and there was universal concern at any rise in the rate. The reason for the section and the detail of any adverse outcome was always provided. Symphysiotomy featured in all the reports until the late 1960s. As with caesarean section, every symphysiotomy was described and the reason for the procedure recorded. A note was always made of the mother's condition after the symphysiotomy and when leaving the hospital and at her six-week check up. The records and the descriptions contained in the hospital's Annual Reports are not indicative of many serious outcomes for mothers post symphysiotomy. The poor outcomes which did occur - usually when the symphysiotomy failed to deliver the baby and the mother had to undergo caesarean section or if the baby was lost - were identified and admitted. Injuries were mainly of a transient nature. A ready association between symphysiotomy and disability is simply not discernible. Records show that a healthy new baby born within 12/18 months after the procedure was

extremely common. There were very few cases of what is termed *voluntary sterility*.

#### LITERATURE ON SYMPHYSIOTOMY

55. Long before symphysiotomy became an issue in Ireland, all known studies on the operation and its benefits or failings were fully and comprehensively examined by Dr. Kenneth Bjorkland of the Karolinska Institute of Stockholm in his article *Minimally invasive surgery for obstructed labour: a review of symphysiotomy during the twentieth century (including 5000 cases)*. The article was published in the British Journal of Obstetrics in March 2002. Bjorkland quoted Dr. V.J. Hartfield “*In the 200 years since symphysiotomy was first performed it has provoked considerable emotions amongst obstetricians. In our own time, uncritical advocacy and uninformed condemnation have combined to so bemuse the average obstetrician that if he ever considers the operation at all it is with indifference*”<sup>31</sup>.
56. As a lay person reviewing medical records and existing literature, I find myself in total agreement. There were few uncritical advocates of symphysiotomy found but there is no shortage of uninformed condemners.

#### MODERN LITERATURE ON SYMPHYSIOTOMY

57. Since that study, articles which favour the use of symphysiotomy in certain cases continue to be published. In May 2009 S.M. Menticoglou of the Women’s Hospital in Winnipeg, Manitoba, Canada wrote in the Journal of Obstetrics and Gynaecology asking **Is there a role for symphysiotomy in developed countries?**. He concluded that like Bjorklund (2002) and Verkuyl (2007) symphysiotomy deserves a reinstatement, not just in

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<sup>31</sup> NZJ Obstetrics and Gynaecology 1973.

developing countries, but also in developed countries. He provided details and outcomes in 6 recent cases performed in his hospital in Winnipeg.

58. The current manual for managing obstetric emergencies and trauma MOET published by the Royal College of Obstetricians and Gynaecologists contains a chapter on symphysiotomy and outlines the technique. A similar chapter is contained in the *The Johns Hopkins and International Federation of Red Cross and Red Crescent Societies Public Health Guide for Emergencies*, a textbook that has been widely used in the classroom and the field.
59. The authoritative Cochrane Reviews, considered the gold standard of best practice in medicine state that “*Symphysiotomy is an operation to enlarge the capacity of the mother’s pelvis by partially cutting the fibres joining the pubic bones at the front of the pelvis. Usually, when the baby is too big to pass through the pelvis, a caesarean section is performed. If caesarean section is not available, or the mother is too ill for, or refuses, caesarean section or if there is insufficient time to perform caesarean section (for example when the baby’s body has been born feet first, and the head is stuck), symphysiotomy may be performed. Local anaesthetic solution is injected to numb the area, then a small cut is made in the skin with a scalpel, and most of the fibres of the symphysis are cut. As the baby is born, the symphysis separates just enough to allow the baby through. Large observational studies have shown that symphysiotomy is extremely safe with respect to life-threatening complications, but rarely may result in pelvic instability. For this reason, and because the operation is viewed as a ‘second-class’ operation, it is seldom performed today. Health professionals fear censure<sup>32</sup> should they perform a symphysiotomy which leads to complications. Proponents argue that many deaths of mothers and babies from obstructed labour in parts of the world without caesarean section facilities could be prevented if symphysiotomy was used. This review found no randomized trials evaluating symphysiotomy.*

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<sup>32</sup> The reviews refer to Irish litigation on symphysiotomy.

56. A very recently published study **Symphysiotomy for obstructed labour : a systematic review and meta-analysis** BJOG (29.04.2016) looks at the best available evidence contained in 7 studies of 1266 women from low- and middle-income countries (as per the World Bank definition) and compared the morbidities between symphysiotomy and caesarean section. The very detailed review of all recent studies (meta-analysis) showed no significant difference in maternal or perinatal mortality with symphysiotomy when compared with caesarean section. There was a reduction in infection but a small incidence of fistulae and stress incontinence with symphysiotomy. There were more haemorrhages and still births with caesarean section. The conclusion was that there was no difference in key outcomes of maternal and perinatal mortality with symphysiotomy when compared with caesarean section.
57. The most recent edition of *Chesser Moir on Obstetric Surgery* contains a chapter on symphysiotomy.
58. All these studies have one common feature: there is no suggestion or indeed mention that symphysiotomy leads to a life time of pain or disability. The studies all outline the dangers when the operation is not carried out by experienced operators and when the technique is not followed. They outline that post operative pain and walking difficulties are generally short term with full recovery expected within 3 months.
59. The commentary is somewhat different in Ireland. Two recent Irish papers examined the findings of two expert groups set up by HSE in 2004 and 2005 to examine the needs of women who had undergone symphysiotomy.
60. The first study relates to radiological findings of a group of 25 women who attended the review process in Cork. The second is a review of the subjective claims made made by 37 women who attended the Cappagh assessment in Dublin.

61. The Cork study compares the findings of pelvic x-rays taken of the women who attended the HSE review with similar radiology of other 25 women of matched age and parity who did not undergo symphysiotomy. The study found that the symphysiotomy group was much more likely to suffer high grade sacroiliac joint osteoarthritis while the control group had a higher incidence of para-symphyseal joint degeneration. In both studies, the women who attended had undergone x-ray examination and presented their own complaints to a panel of experts. The fact of symphysiotomy was accepted without proof. It is now known that several women who attended these two reviews were incorrect in their belief that they had undergone symphysiotomy. There is a possibility that the open method technique was used for longer in the Cork hospitals. Whether the open method, where the arcuate ligament was cut contributed to a wider separation than the later closed partial incision - the Zarates method where the arcuate ligament was preserved, contributed to the findings in the Cork study is not known.
62. I have no doubt that the experts involved in conducting those studies will view my findings and assessments of this much larger group of women with interest provided that they accept my caveats in relation to the ex gratia, non-adversarial and above all compassionate and sympathetic nature of the Scheme<sup>33</sup>. It has also to be understood by obstetricians who perform symphysiotomy in field hospitals where caesarean section is culturally unacceptable or otherwise unavailable, that the threshold for finding significant disability was deliberately set low in this ex-gratia Scheme.
63. Ultimately, the great value of this Symphysiotomy Payment Scheme is that so many elderly women who underwent symphysiotomy now have closure and have received a sum of money quintessentially for them. For the 185 women who were mistaken in their belief that they underwent either

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<sup>33</sup> A comparative study is being undertaken in the radiology department of the Mater Hospital in Dublin at the moment

pubiotomy or symphysiotomy, they need have no further concerns that they are either *victims* or *survivors of symphysiotomy*. It is hoped that whatever the outcome of their application, they are aware that I, with a full legal and medical team, have carefully and individually examined their records. They have all been provided with reasons for the determination of their claims.

64. It is for obstetricians and orthopedic surgeons to analyse and make use of the findings, especially the review of radiology prepared by Professor Leo P Lawler of UCD and the Mater Hospital. Further chapters will address in more detail how assessments were made and the historical context of symphysiotomy in Ireland.
65. For the public at large, the purposes of the Scheme were fulfilled by an objective but compassionate assessment of the evidence rather than by irresponsible rhetoric or as Bjorkland described *uncritical advocacy and uninformed condemnation*. It is hoped that this report will lead to understanding of the framework and background of the era of our past social history when contraception was forbidden by Church and State. Symphysiotomy became an accepted obstetric procedure in all major hospitals until fundamental changes in the management of primigravid labour were introduced. At the same time, repeat caesarean section became safer for mother and baby rendering symphysiotomy generally redundant. It is hoped that the findings will quell the hurt and anger of the elderly women who have undergone the procedure and that this subject will now be laid to rest.

#### **COSTS OF RUNNING THE SCHEME**

66. The Scheme awarded a total sum of:
- €29.8m to 399 successful applicants.
  - €2.08m including VAT at 23% was paid to Solicitors for assisting those applicants and for costs incurred for proceedings in the High Court.

67. Additional costs were incurred in the examination and investigation of all the symphysiotomy/pubiotomy claims which have amounted to under €105,000.
68. The Scheme's administrative costs - which include my judicial salary for 2 years of €142,000 (net) / €313,000 (gross), gross fees to 3 Counsel of €590,000 (net of VAT) / €725,000 (inclusive of VAT), stationery & telephones, broadband & IT services, cleaning, rent & utilities amounted to just under €1.2m. **No travel or personal expenses were sought or received.**

#### **ACKNOWLEDGMENTS AND THANKS**

I owe a debt of deep gratitude to a number of very significant players who assisted me in my task as judicial assessor. First I thank every member of my wonderful legal team and our administrative team. Denise Brett SC, Donal McGuinness BL, Rebecca Broderick BL, shared their very real talents with me. I offer a very special thanks to my personal assistant Patricia O'Shea. Barbara Walsh, Pauline Clifford and Ann Mulvaney provided the active administrative support needed. I have insufficient words in gratitude for their unstinting support and for the exceptional quality of their endeavours as part of the team and for their capacity to work long hours with good humour and efficiency.

I was fortunate to have the assistance of a medical team on hand to advise and explain. I am particularly indebted to Dr. Peter McKenna, Director of Obstetrical Services at the Rotunda Hospital and himself a former Master and to Professor Leo Lawler, Director of Radiology Services at the Mater Hospital and visiting Consultant to the Rotunda Hospital. Both these busy specialists attended for weekly meetings to advise and discuss. Mr. Frank McManus and Mr. James Cashman, both Orthopedic Surgeons, examined a number of applicants when advice and expertise was required. Mr. Cashman who specialises in pelvic injuries

attended with Professor Lawler to lead me through the meaning of radiology findings and to explain the anatomy of a woman's pelvis in comprehensive detail. I am grateful for their patient instruction and guidance.

I thank Professor John Bonnar who was extremely generous with his expertise and time. I thank Mr. Seamus Smith who advised on urological surgery, Dr. Henry Bourke who shared his knowledge of symphysiotomy in Nigeria, Mr. Peter Bowen-Simpkins for meeting me many times and for meeting the experts who advised me and for attending at a joint discussion with them. Professor James Dornan former Vice-president of the RCOG and Dr. Barry O'Reilly, Consultant Urogynaecologist provided invaluable advice on female incontinence and led me to much literature on the subject. The validity of my objective findings was possible only because of the ready availability of all of these specialists.

I am very grateful to Professor Glen Mola, Director of Obstetric Services at the University Hospital at Port Moresby in Papua New Guinea who met me and explained so much about the symphysiotomy procedure. He and Professor Douwe Verkuyl of the Netherlands ensured that I was made aware of current studies relevant to this Scheme.

The workings of the Scheme imposed much extra work on the patient liaison departments of the various maternity hospitals where symphysiotomy was either performed or claimed. While I did not meet any of them, I am aware that they provided all documents sought by my legal counsel Denise Brett SC with speed and good humour. I particularly wish to thank Nicole Kennedy of the NMH on whom a very great burden was imposed. I thank Siobhan Lyons of the Coombe Hospital, Anna Mooney of the Rotunda, David Neville of Cork University Hospital, Camilla Coogan of the Lourdes and Joanne White of the HSE North Eastern region. The Scheme would have been unable to function without their fulsome assistance and their efforts to track down Hospital Registers, files and Annual Clinical Reports.



The Library staff of Trinity College Dublin and the Royal Academy of Medicine in Ireland were helpful and generous in every way, locating books, articles and reports not otherwise available to us. I am very grateful to them.

I cannot praise James Gorman of the Patients' Private Property Central Unit and Maria Dillon, Solicitor of J.D. Scanlon & Co. more highly for all their efforts in assisting applicants who are currently living in nursing homes and suffering from a degree of dementia to avail of the user friendly and cost neutral Patients' Private Property scheme. I am also grateful to the President of the High Court and the Office of the Wards of Court for facilitating and expediting the wardship proceedings in so many cases.

I thank Professor Oonagh Walsh of Glasgow Caledonian University and Dr. Jacqueline Morrissey for their assistance.

Finally, I am indebted to Frances Spillane, Mary Jackson and Kara Prole of the Department of Health for their positive can-do attitude throughout the workings of the Scheme. They ensured that the needs of the Scheme were met and a system set in place for the efficient payment of awards to applicants. They were at the same time assiduous not to affect or interfere with my independence as Judicial Assessor.

Thank you.

**APPLICATIONS****COMMENCEMENT OF THE SYMPHYSIOTOMY PAYMENT SCHEME****METHODOLOGY**

69. Our first task was to familiarise ourselves with the reports prepared by Professor Oonagh Walsh and Judge Yvonne Murphy and the many sources mentioned in those reports. It was realised that reintroduction of symphysiotomy into obstetrics in Dublin in the 1940s created much discussion and debate. Relevant publications were therefore identified and read.
70. There is in fact a vast amount of literature on the subject of symphysiotomy. It is clear that the issue has often been divisive. It was particularly noted that much negative commentary originates from writers/commentators who have no personal experience of symphysiotomy and who appear to act from preconceptions using quotations from writers of a century ago. However, the vast majority of literature - where the authors are actually symphysiotomists - advocates a place for symphysiotomy as an alternative to caesarean section for mild to moderate disproportion in low resource situations.
71. Much if not all of the literature since the 1960s reports a relatively low rate of morbidity following symphysiotomy<sup>34</sup>. However, as symphysiotomy is almost never carried out in western countries, most modern papers in the English language have reported on case studies from Africa and Papua New Guinea where families remain large and delivery by caesarean section may be seen as a reproductive health failure<sup>35</sup> or may simply not be available in time. The easy dismissal of the value of these reports (as

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<sup>34</sup> Bjorkland + BJOG 29 4 2016

<sup>35</sup> Journal of Obstetrics and Gynaecology, August 2004

jungle medicine) written by highly experienced obstetricians who attach the same value to the lives of black women and their reproductive health as to Western women who have access to highly resourced obstetric facilities is personally, deeply offensive. The use of symphysiotomy if it ensures a well mother and a healthy baby in developing countries is precisely the shared objective of obstetricians everywhere.

72. As previously mentioned, the history of symphysiotomy in Ireland was very fully explored by Professor Walsh. To a great extent, her scholarly report has been ignored by sections of the media who appear to prefer the more lurid and unfounded accounts projected by some activists and bloggers. I am therefore not sanguine that there will be any change in the manner of reporting of the subject.
73. Once we were familiar with the literature on the subject of symphysiotomy, a website was set up and to provide advice and progress statistics on a weekly basis. The feedback was that the site was very regularly visited. The website was also used to inform applicants, their families and assisting solicitors on a near weekly basis of which applications were being assessed or about to be assessed and to alert them of any problems being encountered.
74. Applicants and their family members were encouraged to contact the office by phone for advice and information. As a result of this contact it was decided that applicants who were receiving legal assistance should be kept abreast of the progress of their claims and that correspondence with their assisting solicitors would be copied to them. I also determined that no information regarding an applicant's claim, assessment or award would be provided to family members who telephoned unless the applicant herself requested us to discuss her affairs with named family members. This was in order to deal with several quite inappropriate enquiries regarding a mother/grandmother's award.

75. It was also decided that all awards would be electronically transferred to the applicant's account held in her sole name<sup>36</sup>. If an applicant was very elderly, we sought assurances that she was capable of handling her award. When there was any doubt as to an applicant's mental capacity or when a proxy was made the application on behalf of an applicant who lacked mental capacity, the award was not transferred until she was taken into wardship or arrangements were made for the award to be managed by the HSE Patients' Private Property Central Unit.

## GENERALLY

76. Applications were received between the 10<sup>th</sup> November 2014 and the closing date of the 5<sup>th</sup> December 2014. 563 applications claiming either symphysiotomy or pubiotomy were received in that time. 27 further applications were received between the 5<sup>th</sup> December and the 14<sup>th</sup> January 2015. My discretion was exercised to receive 15 of the late applications bringing the total number of claims received in to the Scheme to 578. The total number of applications was 590. The chapter on **Late applications** provides further detail on those applicants.
77. The applications came predominantly from Dublin, Cork and the Louth/Meath area. The biggest number of **claims** - 161 - named the Lourdes Hospital as the venue for the claimed procedure. 96 applicants named the NMH. 72 named the Coombe; 32 named the Rotunda and the remaining 217 named the 3 Cork Hospitals, St. Kevin's, St. James's, St. Columcille's, Galway and various nursing homes and smaller hospitals<sup>37</sup>.
78. The youngest claimant to receive an award for symphysiotomy was 51<sup>38</sup> and the oldest was 96 years. The majority of claimants were over 75. 107 applicants were aged between 85 and 96 at the time of application.

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<sup>36</sup> Unless she had a joint account with her husband.

<sup>37</sup> Claims are distinguished from awards. All applicants had to establish that they had in fact undergone surgical symphysiotomy. This applicant underwent symphysiotomy for an assisted breech delivery.

<sup>38</sup> The youngest applicant was 43 but she did not have a symphysiotomy.

79. 350 applicants claimed that they had suffered significant disability under 1B;  
150 applicants claimed under 1A, that is they had undergone symphysiotomy but had not suffered disability;  
13 applicants claimed under 1C only ;  
12 applicants claimed 1C with significant disability;  
6 applicants claimed that they had undergone pubiotomy under P1 or P2;  
47 applicants submitted multiple forms claiming both symphysiotomy and pubiotomy, with or without disability.

#### **HOW ASSESSMENTS WERE MADE**

80. All objective evidence received was carefully considered and any doubt was generously applied in an applicant's favour. If an applicant identified a specific disability, her subsequent delivery records and her GP records were examined for evidence of any treatment or investigation carried out which was capable of supporting the fact of that disability. Her personal statement was reviewed and considered in the totality of the evidence. That is not to say that all statements and reports were accepted uncritically. Many personal recollections reduced to a statement were simply not corroborated by the contemporaneous medical records of the symphysiotomy delivery. Many applicants did not undergo symphysiotomy. Many subjective and partisan reports were received but excluded in favour of objective contemporaneous reports. Reports described as medico-legal reports, obtained specifically for the application and which merely repeated an applicant's uncorroborated claims were afforded little weight<sup>39</sup>. GP records which outlined symphysiotomy related conditions and referrals for x-ray were of primary importance. Annual Clinical Reports and records of subsequent pregnancies and deliveries were major sources of objective evidence. Each application received an individual, careful and fair assessment. Medical advice was sought to explain delivery records and when claims could not be reconciled with

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<sup>39</sup> More fully elaborated lower in the sub-chapter on how assessments were made.

facts, the applicant was examined by an orthopedic surgeon or by a gynaecologist. Some applicants were examined by several experts.

81. Each application received was stamped with a date stamp, awarded a file number and acknowledged. This file number was described as its SPS number. This SPS number was then quoted in all further correspondence. Each application form was subjected to a first level scrutiny to determine whether it was fully completed and that the date and place of the claimed symphysiotomy was identified and the number of children born to the applicant provided. The applicant's identity was established by her birth certificate. In the rare cases where for good reason, a birth cert was unavailable, secondary formal identification was accepted<sup>40</sup>. One of the questions on the form to be answered was whether the applicant had sought her medical records from the hospital where the symphysiotomy delivery took place. The vast majority of applicants answered yes and established their claim by furnishing a copy extract from the relevant hospital's birth register<sup>41</sup>. This was sufficient to establish that the fact of the symphysiotomy.
82. If the form was fully and correctly completed and the claim was made for significant disability and if documents establishing the symphysiotomy procedure were supplied, the file moved to the next level of assessment.
83. Every single file was personally reviewed and assessed by me. Members of my legal team also undertook their independent reviews of available documents and then discussed their views with me. Experts were consulted in every case where doubt existed. Generally, the experts attended at our office once weekly for case conferences. On other occasions the conferences were in the lecture theatre in the Mater Hospital where radiology could be put up on a wide screen for the experts to explain the findings. Where evidence of a disability capable of connection or temporal association with symphysiotomy was discovered,

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<sup>40</sup> Eg passport, social welfare card, baptismal certificate

<sup>41</sup> Accompanied by the relevant obstetric records, where available

an offer for significant disability was made<sup>42</sup>. It was for the applicant to accept the offer or to continue with proceedings in being or to consider commencing litigation for damages.

84. Ultimately, the decision in all cases was mine. It was my practice to assess a claim as one of significant disability at a relatively low threshold once any objective evidence capable of supporting a symphysiotomy related disability was found. The words *any* and *found* are used advisedly as often, volumes of GP notes and/or hospital records were delivered to the Scheme without any effort to identify the significant disability claimed. A great deal of expansion was applied to the word *any*.

85. **MEDICAL EXPERTS ASSISTING THE SCHEME**<sup>43</sup>

- Dr. Peter McKenna, former Master of the Rotunda and consultant obstetrician and gynaecologist and part of the Cappagh Expert Review Group
- Professor Leo Lawler, Director of Radiology Services, consultant radiologist Mater Hospital and visiting consultant to the Rotunda Hospital
- Mr. Frank McManus, consultant orthopaedic surgeon and one of the experts appointed by the HSE for the Cappagh Review in 2005 which examined the needs of 37 patients who claimed to have undergone symphysiotomy
- Mr. James Cashman, consultant orthopaedic surgeon with particular expertise in pelvic injuries Mater Hospital

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<sup>42</sup> It was rarely possible to go beyond this standard due to the long period since the symphysiotomy and the many intervening factors and events such as additional pregnancies, accidents, medical conditions and age.

<sup>43</sup> Professor John Bonnar, Mr Seamus Smith, Dr. Henry Bourke, Professor Glen Mola, Professor Douwe Verkuyl, Dr. Barry O'Reilly and Mr. Peter Bowen-Simpkins and Professor James Dornan were generous with advice and expertise when invited to assist.

86. **DIFFICULTIES ENCOUNTERED:**

- Obtaining records
- Secondary Evidence to establish symphysiotomy
  - Scar evidence
  - Radiology
- Subjective medical reports
- No specific disability identified
- Difficult assessments: Belief v Fact

**OBTAINING RECORDS**

87. If any application form recorded that the claimant was unable to establish the fact of symphysiotomy, a letter was written to her or to her assisting solicitor enquiring what efforts had been made to obtain relevant records. It was learned that some applicants had encountered considerable difficulty in obtaining the required information to confirm the symphysiotomy especially when smaller hospitals that had closed down many decades earlier were involved. Particular problems were encountered with nursing homes. The difficulties were not confined to these situations as even in major hospitals, clinical records were of such vintage that they had been destroyed<sup>44</sup> and all that remained were Birth Registers held in storage.

88. The Lourdes Hospital in Drogheda was the exception in that it had maintained in very good condition almost all its clinical records. However, most hospitals operated a policy of destroying closed patient files after 25 or so years.

89. In cases of difficulty with records, we assisted applicants by conducting our own enquiries to establish the claimed symphysiotomy. Contact<sup>45</sup> was

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<sup>44</sup> in normal course of record management norms for medical records

<sup>45</sup> Consent to investigations had been obtained from all applicants by way of Form 2 in the application process



made with as many hospitals as could be identified from the applications lodged<sup>46</sup>. HSE liaison officers and county & national archives were important starting points. In this way Registers for the Coombe, Rotunda, NMH and St James's in Dublin; the Erinville, St. Finbarr's<sup>47</sup> and the Bons Secours in Cork and the Airmount Hospital in Waterford were provided or located and examined<sup>48</sup>. We learned that patient files from the Galway General / Regional Hospital were stored on microfiche. Some registers of the long closed Stella Maris nursing home in Dublin were in the National Archives. The records from St Kevin's Hospital in Dublin, originally thought to be irretrievably lost were available in the archives of St. James's Hospital. Some additional Registers from the Rotunda were stored in the National Archives. Records from the Cottage Hospital in Drogheda were stored in the old building now under HSE control as a home for elderly patients. Any patient files sought were provided by the current management of the Home<sup>49</sup>. We made no progress in locating any documents for the Bedford Row Hospital in Limerick, the Leinster Nursing Home in Dublin or any nursing homes generally. We were unable to obtain records from the very recently closed Mount Carmel Hospital in Dublin.

90. All the major hospitals in Dublin were without exception, extremely helpful in searching their birth registers, theatre records and admission/discharge cards in an effort to establish whether symphysiotomy was performed on a particular patient. All available clinical records were furnished whether as photocopies of originals or printouts of records held on microfiche. In the Erinville and St. Finbarr's hospitals, the only available sources were the birth registers. If the particular register was missing, then the registers containing records of an applicant's subsequent deliveries were sought and examined to determine whether 'previous symphysiotomy' was noted

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<sup>46</sup> The Coombe, NMH, Rotunda and St James' in Dublin; CUH & the Bons in Cork; Our Lady of Lourdes; Louth County and Cottage in Louth, Our Lady's in Navan; St John's and Limerick Regional in Limerick, Galway University in Galway, Waterford University Hospital in Waterford; Daisy Hill in Newry; Clonmel in Tipperary.

<sup>47</sup> for Registers of St Finbarr's & Erinville Hospitals

<sup>48</sup> members of the legal team travelled to Cork, Waterford and each of the Dublin Maternity Hospitals & St James

<sup>49</sup> As we found with nursing homes and small hospitals, symphysiotomy was not performed. The patient was usually sent to the nearest large obstetric hospital if any difficulty was encountered. Dr Connolly was called in to conduct a symphysiotomy once to address a case of fetal abnormality.

at that later birth. If an applicant was identified in any of those records and a symphysiotomy was noted, then the symphysiotomy was deemed established.

91. There were very few instances where we were unable to assist. However, a small number of cases were resistant to any action. We were unable to assist because the application form provided nothing more than a name and address and the name of the hospital where the symphysiotomy was said to have been performed. Despite several written reminders and notices posted on the official website, nothing further was furnished and there was no engagement with the Scheme<sup>50</sup>. In each case, we carried our enquiries as far as we could but were generally inclined to believe that experience showed the named hospital was unlikely to have carried out any symphysiotomy as claimed. Those applicants were ultimately declared ineligible.

#### **SECONDARY EVIDENCE TO ESTABLISH SYMPHYSIOTOMY**

92. When all efforts failed to obtain records, we moved to seeking secondary proof of symphysiotomy by scar and radiology evidence. A report from a gynaecologist or a GP identifying a symphysiotomy scar and/or a radiology report showing a wide diastasis inconsistent with natural sub-luxation was accepted as evidence of the claimed procedure. If an applicant had a report from her own nominated GP or gynaecologist, this was accepted. If the applicant had no such report, we generally arranged for examination by Dr. McKenna and for an x-ray to be read by Dr. Lawler.

#### **SCAR EVIDENCE**

93. Establishing the symphysiotomy by scar evidence was not quite as easy or as clear cut as we had been led to believe. The large body of literature written by practitioners of symphysiotomy over the last 7 decades informs that there are several techniques by which symphysiotomy was/is

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<sup>50</sup> These cases are discussed under the INELIGIBLE CLAIMANTS section.

performed. The studies published by Spain, Barry and Feeney who conducted the earliest operations in Dublin in the 1940s and early 1950s describe the open symphysiotomy technique involving a fairly large 5 or 6 cm horizontal incision requiring several closure sutures. This gave way to a vertical incision of similar length and then ultimately to a sub-cutaneous or closed operation described by Zarates in 1955. This Zarates technique often described as the stab incision involves a small incision requiring only one suture for closure and therefore leaves a very small scar over the symphysis pubis. The 1959 Clinical Report for the Lourdes Hospital stated that the Zarates method was now being utilised in 50% of symphysiotomy procedures. The 1962/63 Report then stated that the Zarates method was the exclusive technique in all cases. It can probably be safely assumed that the *open* symphysiotomy described by the former Masters of the NMH and the Coombe fell out of favour before that in the 3 Dublin maternity hospitals. It is however suspected that the open method was always used in the Cork hospitals as scars examined in patients from those hospitals appear to be consistent with the larger vertical incision<sup>51</sup>. When symphysiotomy was performed to release the trapped after-coming head in breech deliveries in hospitals in the 1970s and 1980s, the technique was almost invariably described as “*partial division*” or the “*stab incision*” which indicated the sub-cutaneous Zarates technique. This is the method described in most modern literature where no suture is applied to the small incision.

94. Very few obstetricians or gynaecologists or GPs in Ireland have ever performed a symphysiotomy or pubiotomy and they therefore have no first hand knowledge of the procedure or of the appearance of the expected scar from procedures carried out 5/6 decades earlier. Dr. Peter McKenna who advised the Scheme had never performed a symphysiotomy nor had he assisted at any such procedure. As part of his obstetric training in the UK, he had participated in a demonstration of a symphysiotomy on an anatomical model. He acquired his experience of the appearance of

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<sup>51</sup> Surgical techniques in symphysiotomy are described in the later chapter with that title.

symphysiotomy scars from his examination of women who were known to have undergone the procedure. Mr. Peter Bowen-Simpkins who examined many applicants had also acquired his experience in this way. Similarly, Dr. Barry O'Reilly<sup>52</sup>, Dr. Peter Boylan and Professor John Bonnar had acquired experience from examining women involved in symphysiotomy related litigation. It was universally agreed that whatever procedure was used, a symphysiotomy could not be performed without leaving a scar – however faint or small. This small group are the only doctors who have regularly examined those who claim to have undergone symphysiotomy for the presence of an appropriate scar.

95. Lack of experience/knowledge of the appearance of symphysiotomy scars first and quite alarmingly came to the fore in mid-2015 when medical reports were received from gynaecologists and general practitioners purporting to identify symphysiotomy scars in the labia or some inches above or lateral to the pubic symphysis and in some cases, deep in the groin.
96. Before those very obvious deficits in experience were recognised, it had been my practice to accept the validity of medical reports where a symphysiotomy scar was said to have been identified and for those reports to trump clinical records which were silent as to symphysiotomy. With experience, caution replaced unqualified acceptance of such medical reports and a more holistic approach was adopted. In the meanwhile, I also learned that the Clinical reports of the Dublin hospitals and the Lourdes Hospital *always* identified each symphysiotomy performed and provided the patient's details. The Clinical Reports were often more accurate than the Birth Register extracts which on a few occasions made no mention of a symphysiotomy carried out on a prophylactic basis some days or even weeks earlier. We found no errors in the recording of symphysiotomy carried out during labour in the Dublin Hospitals and we learned through time that there was no evidence to support any contention

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<sup>52</sup> Dr O'Reilly had participated as an expert in the HSE examination of 25 women from Cork who claimed to have undergone symphysiotomy

that symphysiotomy was carried out in nursing homes. We found no errors in the recording of symphysiotomy at the Lourdes Hospital.

97. As experience was obtained we were able to match the patient's identifying number on the Birth Register entry with the number in the anonymised list of patients who had undergone symphysiotomy and whose case was described in the Clinical Reports. If no match was found in any of those source documents, I learned that I could be confident that no scar would be found. However, no applicant was found ineligible without checking these sources and also the theatre registers and the admission and discharge cards. Unfortunately, errors were made because of my earlier acceptance of medical reports purporting to identify a symphysiotomy scar.
98. Establishing the fact of symphysiotomy was a prerequisite to any assessment for payment of an award. When records did not support the claimed symphysiotomy or, as occurred in very many cases<sup>53</sup>, there were no records, Dr. McKenna was called upon to examine many of the applicants<sup>54</sup>. He then cautioned that stretch marks over the symphyseal area in elderly and sometimes overweight patients could easily be confused for a symphysiotomy scar even when an experienced observer. He also noticed that tights, underwear and trousers could leave an indentation on the skin which could temporarily mimic a vertical scar. He advised that in cases of doubt, radiology should also be considered and a full history taken before coming to any firm conclusion. He recommended taking second opinions in several cases. Fortunately, in most instances, there was no doubt about the absence or presence of a symphysiotomy scar. Either one was evident or it was not. The problems that did arise were when the lower abdomen was either pendulous or crisscrossed with stretch marks and/or surgical scars from urological and gynaecological repairs and/or from hormone implant incisions and old and extensive vertical incisions from caesarean section.

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<sup>53</sup> 175 applicants were unable to provide proof of their claims

<sup>54</sup> Some applicants preferred to consult with their own expert.

99. Unfortunately, before the issues with stretch marks and unfamiliarity with symphysiotomy scars were identified, I had relied on possible errors contained in medical reports. Prior to that, my acquired knowledge on the hospitals where symphysiotomy was likely to have been carried out<sup>55</sup> and of the custom of recording every symphysiotomy in the Dublin and Drogheda hospitals caused me to seriously doubt the validity of scar evidence in certain cases. However, those doubts were suppressed and medical evidence of a scar over the symphyseal area was accepted without question. Thereafter, extreme caution was exercised with scar evidence where the symphysiotomy was unsupported by the available delivery notes or where the claimed symphysiotomy birth was associated with a hospital or nursing home with no history of performing the procedure. In 2 such cases of possible error, the symphysiotomy birth was said to have taken place in a hospital where it is now known, had not yet been constructed.
100. When the difficulty with stretch marks was appreciated, I discussed the issue with other examining gynaecologists who agreed with Dr. McKenna and accepted that it is possible that stretch marks could be mistaken for symphysiotomy scars in cases from so long ago. I am however satisfied that these scars were identified in good faith but nevertheless the mistakes explain why symphysiotomy was sometimes found in unusual venues or was not mentioned in relevant records where one would expect to see it noted. None of the suspect cases was revisited.
101. It is highly probable that several applicants received awards in error. In 3 extremely troublesome cases, notwithstanding very extensive investigations, even with the assistance of specialists, I was simply unable to exclude the possibility that the applicants had undergone a symphysiotomy procedure. In those cases, the birth records were either incomplete or unavailable and medical evidence was unsatisfactory. I

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<sup>55</sup> In training hospitals where expertise was available

formed the view that it was better to err in making an award to an elderly applicant convinced of the truth of her claim than to be wrong and refuse an award to a deserving applicant. In approximately 6 other cases, earlier reliance on scar and in one case, radiology evidence led me into error. I take responsibility for my errors. In 2 cases where reliance was placed on medical opinion, records which were not available at the time of assessment subsequently became available from stored archives. They confirmed earlier suspicions that no symphysiotomy procedure had been performed.

## **RADIOLOGY**

102. Radiology was a vital tool in assisting to establish the fact of a surgical symphysiotomy when documents were unavailable and when scar evidence was equivocal. In the early days of the Scheme's assessments, radiology reports were presented *as proof of the procedure* in a number of cases where no other evidence was presented. At that time, I was not yet in a position to be confident that symphysiotomy was almost invariably recorded on Birth Registers and in annual Clinical Reports. Even at that stage when we were on a steep learning curve, I considered that these radiology reports were of no evidential value as the very eminent radiologist involved had been wrongly informed that the applicant had undergone *previous symphysiotomy*. Quite reasonably, the radiologist relied on that information and read the x-ray or scan as representing a pubic joint that had approximated completely and a report was written to this effect. An example of such a report is:

*History of previous symphysiotomy noted: There is now restoration of anatomic alignment without diastasis or loss of congruity at the symphysis pubis.*

*Impression: previous symphysiotomy with restoration of anatomic alignment.*

103. Where this possibly orchestrated lack of candour originated is not possible to identify but was extremely disappointing: the radiologist was misled and the report which no doubt had a cost implication for the applicant was useless. Such misleading reports<sup>56</sup> led to my insistence of the Scheme's own examination of all radiology unless the radiologist had identified and measured key features - separation, alignment and condition of sacroiliac joints.
104. As with symphysiotomy scars, it was observed that quite understandably, modern radiologists have had no exposure to surgical symphysiotomy and therefore rarely measured any diastasis seen. Professor Lawler who is a visiting consultant at the Rotunda Hospital had experience in obstetrics and radiology and was therefore in a position to advise on the appearance of a normal pubic symphysis. He was aware that my function as Judicial Assessor was to identify those women who had undergone a surgical symphysiotomy and in so far as it was possible, to report on any abnormalities in the pubic joint, the hips and the sacroiliac joints. From the commencement of the Scheme, he had difficulty in identifying just what pelvic instability meant in the context of a surgical procedure rather than a traumatic pelvic ring injury. This issue has remained problematical especially when viewing the imaging of a joint and pelvis so many decades after the fact of the symphysiotomy.
105. Professor Lawler created a list of features to be addressed when he examined any pelvic radiology. When asked to read any existing radiology he looked out first for any evidence of pubiotomy. He then examined the symphysis pubis for evidence of separation (diastasis) and translation (vertical movement of the two halves of the joint), for sclerosis, osteophyte formation, cysts, capsular hypertrophy or edema. He then examined the hips and the sacroiliac joints. He finally expressed his opinion as to whether the patient had undergone symphysiotomy on a scale of I, II or III. I was positive. II was equivocal and required more investigation and III

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<sup>56</sup> Several applicants (16) who sought to rely on these reports were ultimately found not to have undergone symphysiotomy and their claims were declared ineligible.



was no evidence of prior symphysiotomy. He was given no information on the applicant apart from her name and date of birth. He was given no information on the status of the claimed symphysiotomy. In this way, we obtained an objective report.

106. It is fully accepted that radiology has limitations as a diagnostic tool. It cannot exclude symphysiotomy when a completely normal symphysis pubis is found. Many applicants who we knew from reliable records had undergone symphysiotomy, were categorised as grade III. Radiology can however confirm that surgical intervention has occurred when a wide diastasis and significant translation is demonstrated or if metal artifact is seen on MRI. Any diastasis and any degree of translation seen were measured electronically. Frequently, radiology provided the only evidence to permit a finding of significant disability. It was also an extremely valuable tool for objectively demonstrating abnormal conditions of the pubic joint, the hips and especially the sacroiliac joints.

107. Discussion of the role of radiology in the assessment of significant disability brings me to perhaps the most contentious part of my method of assessment. As so many applicants claimed symptoms which were not supported by their medical records, I sought to devise some method by which a degree of objectivity could be introduced to the assessments. It was becoming increasingly evident that a surgically separated pubic joint could fully reapproximate with the passage of time. It was also evident that in some women, the pelvis widens to an abnormal extent during pregnancy and labour and they develop a spontaneous morbid subluxation of the pubis symphysis and the sacro-iliac joints. This occurrence is known as a spontaneous symphysiotomy<sup>57</sup>. In some of those patients, the condition persists after pregnancy and for years although the condition usually resolves with treatment<sup>58</sup>. It was also observed that some applicants who did not undergo surgical symphysiotomy demonstrated radiological findings that were indistinguishable from those of women who

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<sup>57</sup> 23 such cases were identified among the applications

<sup>58</sup> The subluxation of pubic symphysis also occurs in male athletes

were known to have undergone the procedure. Their radiology showed a degree of symphyseal separation, sclerosis and osteophytosis and sacroiliac joint disease<sup>59</sup>. However, it seemed that the symphyseal separation in those cases rarely exceeded 10mm. I therefore decided that any diastasis of 15mm or more in width would be considered to be sufficient evidence to (a) establish symphysiotomy and, much more important for the purposes of the Scheme, (b) to constitute significant disability directly attributable to that symphysiotomy. This decision was made following consultation with Mr. Frank McManus, our advising orthopedic surgeon, Dr. Peter McKenna and Professor Leo Lawler and later ratified by Mr. James Cashman who joined as adviser on pelvic injury in 2015.

108. I fully accept that my decision, solely for the purposes of this Payment Scheme, to consider that a diastasis of 15mm constituted significant disability is unsupported by any orthopaedic literature. I was solely motivated by trying to find some method of distinguishing between normal findings and surgical symphysiotomy findings and to find objective evidence by which significant difficulty could be established, I rationalised that the majority of women who had the procedure are now between 75 and 90 years old and up to 65 years post surgery. Their pubic symphysis had healed with fibrous union with the diastasis still visible on x-ray. This diastasis was not found in women who had not undergone surgical symphysiotomy and was in almost all cases the only objective finding which distinguished the normal population from the symphysiotomy applicants. The premise accepted was that if they had not undergone symphysiotomy, the diastasis would not exist.

109. All the specialists advising me agreed that I would be doing *no injustice* to lower the bar to assess continuing wide diastasis of 15mm or more as sufficient by itself to constitute significant disability. They could not put their support for this proposition any stronger than that. This lowering of

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<sup>59</sup> The Galbraith et al. Cork study of 25 women who did not undergo symphysiotomy showed a greater degree of sclerosis in those women and also that 20% had a degree of sacroiliac arthropathy.

the bar is probably the main reason for finding significant disability in more than 60 cases. Had I not done so, far fewer applicants could have been found to have suffered a medically verified significant condition directly attributable to the symphysiotomy.

110. It will be a matter of keen interest to orthopedic surgeons to find common factors between those women whose separated pubic joint realigned to normal and those which remained separated. A Table showing the applicant's age at the time of applying to the Scheme and past parity and post symphysiotomy parity is found below.

# **APPLICANTS WITH WIDE DIASTASIS:**

AGE	Total Children	Children post procedure	Diastasis 15mm+	Hospital	SI Joints
94	3	1	31	NMH	Normal for age
93	7	5	15	Lourdes	Normal for age
93	8	4	17	Lourdes	Normal for age
92	2	1	28	Nursing Home, Dublin	Normal for age
90	5	4	15	Mayo General	Normal for age
90	5	0	17	NMH	Normal for age
89	9	8	19	Bons Cork	Normal for age
88	6	5	16	Bons Galway	Normal for age
88	5	4	25	NMH	Abnormal
87	6	5	20	Lourdes	Abnormal
87	6	5	16	Lourdes	Abnormal
87	9	5	16	Lourdes	Abnormal
87	10	3	20 <sup>+</sup>	Lourdes	Normal for age
86	5	4	23	Bons, Cork	Normal for age
86	6	5	21	St. Columcille's	Normal for age
86	5	4	18	Coombe	Normal for age
86	7	6	30	Lourdes	Normal for age
86	3	2	18	Coombe	Normal for age
85	5	4	38	St. Finbarr's	Abnormal
85	6	5	20	NMH	Abnormal
85	5	3	21	NMH	Abnormal
84	2	1	20	St. Finbarr's	Abnormal
83	7	6	40	Galway Regional	Abnormal
83	7	4	33	NMH	Normal for age
82	2	1	27	NMH	Normal for age

82	5	4	39	Lourdes	Normal for age
82	4	3	18	NMH	Normal for age
82	9	8	27	St. Finbarr's	Abnormal
82	7	6	27	NMH	Normal for age
82	4	3	20	Lourdes	Abnormal
81	5	4	20	Lourdes	Normal for age
81	5	4	20	Lourdes	Normal for age
81	6	5	18	St. Finbarr's	Normal for age
81	3	2	29	Coombe	Normal for age
80	4	3	18	St. Finbarr's	Abnormal
79	4	3	15	St. Finbarr's	Normal for age
79	7	6	20	St. Finbarr's	Abnormal
78	3	2	20	Galway Regional	Normal for age
77	5	3	16	Bedford Row, Limerick	Abnormal
77	3	2	21	St. Finbarr's	Abnormal
76	4	3	20 <sup>+</sup>	Lourdes	Normal for age
76	7	4	20 <sup>+</sup>	NMH	Abnormal
76	4	3	20	St. Finbarr's	Normal for age
76	7	6	20	St. Finbarr's	Normal for age
75	6	5	16	Lourdes	Normal for age
75	6	4	32	St. Finbarr's	Normal for age
75	4	3	28	St. Finbarr's	Normal for age
75	5	4	20	Lourdes	Normal for age
75	3	2	20 <sup>+</sup>	St. Finbarr's	Normal for age
75	5	4	35	Bons, Cork	Normal for age
74	5	4	28	Bons, Cork	Normal for age

74	10	9	10	Coombe	Normal for age
74	3	1	25	St James	Normal for age
73	5	4	16	St. Finbarr's	Normal for age
72	6	5	16	St. Columcille's	Normal for age
72	2	1	16	Lourdes	Normal for age
72	5	4	18	Coombe	Normal for age
71	7	6	27	NMH	Normal for age
69	5	4	20	Lourdes	Abnormal
66	4	3	21	NMH	Normal for age
65	2	1	25	Lourdes	Abnormal
64	4	3	28	Coombe	Abnormal
62	4	3	20 <sup>+</sup>	Lourdes	Normal for age
		<b>Total = 63</b>			

## SUBJECTIVE REPORTS

111. It is a matter of regret that assessments were frequently made unnecessarily difficult by the presentation of generic expert reports where cut and paste findings were made in almost every case including those where symphysiotomy was not established. Sometimes applicants were asked to fill in pre-printed forms which presented a series of highly suggestive symptoms including those not normally associated with surgical procedures which were to be marked on a 1 to 5 measurement, 5 being the worst. The applicants marked themselves as at the worst level of disability under each heading and an identical finding was made in every case. Those reports were found to be unhelpful.

112. Subjective medical reports which contained no more than a repetition of an applicant's account of events had nil value. Whenever the author used emotive language such as *mutilated* and *her life destroyed, never enjoyed a pain free day since or endured a life time of pain*, the reports were

considered of low value. Non-treating doctors sometimes wrote reports so completely at variance with the contents of treating GP's notes that I was obliged to make contact with the treating GP to clarify the issues. A notable example was where an applicant was described as a woman so traumatised and damaged by the symphysiotomy which had caused her *intractable incontinence*, pain and social isolation that she endured it all in silence rather than overcome her pathological fear of doctors and seek medical help. Her own doctor's records depicted an absolutely normal woman who worked outside the home, rode her bicycle to work and attended regularly with her GP for her own and her family's everyday ailments. Another notable case involved reports furnished by three different doctors who each attested to the horrors inflicted on the unfortunate patient by a symphysiotomy. However, no symphysiotomy had ever been performed. A small number of doctors tried to help their patients by writing sympathetic reports at variance with their own contemporaneous records. On countless occasions, it seemed that once the symphysiotomy procedure was identified (usually in 2003/2004), new complaints previously absent from the records spanning decades were made and every health ailment was attributed to symphysiotomy. Again, this phenomenon was observed even where it was ultimately established that symphysiotomy played no role in the applicant's complaints. It can be readily seen why objective contemporaneous records stretching over many years were preferred to recently obtained medico-legal reports from non-treating doctors. It was frequently observed that a major pointer in establishing the probity of musculo-skeletal complaints was evidence of referral for X-ray investigation long before the publicity surrounding symphysiotomy broke thus providing some temporal association with the procedure. Very few referrals were made.

#### **NO SPECIFIC DISABILITY IDENTIFIED**

113. In a large number of applications, we received vast quantities of records. No attempt had been made to link any conditions with symphysiotomy or

indeed to identify the claimed disability. After hours of examination, it was often discovered that they were of no relevance as they related to investigations, procedures and hospitalisations for conditions without even a tenuous connection to symphysiotomy. We eventually had to write asking that the specific disability claimed could be identified and we notified all applicants of this difficulty on the Scheme's website. In very many cases, a possible significant disability was only identified by our own efforts of combing through the bundles of records. Even then, on many occasions, disability could only be assumed when radiology indicated a wide diastasis and/or an abnormal appearing pubic symphysis.

114. Happily, many treating doctors provided objective and helpful reports where either the possible association between symptoms and symphysiotomy or the lack of any possible association with symphysiotomy was explained. We were informed that some treating GPs declined to provide medico-legal opinions because they did not know enough about symphysiotomy to venture a view. The practice notes were provided but it was clear that the patient had never mentioned having undergone symphysiotomy nor had she made complaints referable to any obstetric procedure. I have high regard for the integrity of those family doctors.

115. It is obvious that the rarity of symphysiotomy means that few GPs know anything of the procedure apart from from media reports. This sometimes emotional and sensational reporting has led many highly competent doctors to believe that once a symphysiotomy is performed, pelvic instability, pain and urinary incontinence follow as a matter of course. This probably explains why the reporting of a patient's condition and complaints changed once the possibility of symphysiotomy was raised.

116. So little is known, as opposed to perceived, about the sequelae of symphysiotomy that on a number of occasions, I was reprimanded by an applicant's doctor for reporting that a radiology report received in his



patient's case indicated a completely a realigned pubic joint. This it was declared was an impossibility and a reflection of my ignorance.

#### **DIFFICULT ASSESSMENTS: BELIEF V FACT**

117. Very considerable efforts were taken to thoroughly and fairly examine all applications. Particular difficulties arose in a number of cases where the applicants were firmly convinced that they had undergone either symphysiotomy or pubiotomy and were unwilling to accept the truth of the content of their medical records. Conspiracy theories were not uncommon. Usually the issue was set to rest following gynaecological and radiology examination; sometimes several such examinations were necessary. By way of example of the difficulties encountered was one applicant whose daughter was determined that her mother had undergone a symphysiotomy. As the delivery was in the 1970s, the full hospital chart and records of the birth were available. Those records made no mention of a symphysiotomy, provided no support for symphysiotomy nor was there any reason why the procedure would be carried out. Very surprisingly, an expert report was received where an *obvious palpable symphysiotomy scar* was described. I requested a second examination as the records contradicted the possibility of symphysiotomy. The applicant's daughter rejected this opinion. The applicant was subsequently examined by 3 other gynaecologists but none saw any evidence of any scar in the pubic area. The daughter still rejects the 4 opinions. I have never resolved how the expert came to be so mistaken.
118. Eventually, 12 especially difficult applications remained to be resolved. In each case, the claimed procedure had not been established. In each case there was a degree of equivocation in the different experts reports and there were ambiguities in medical records. One case was found to be *impossible to exclude* and was admitted although doubts were never resolved. The files of the remaining 11 applicants had been intensively analysed in an attempt to determine whether the applicant's strong conviction that she had undergone symphysiotomy was justified. In most

cases, records did not support surgical intervention. In others, there were no records. A discussion conference was held in the radiology lecture room of the Mater Hospital, one of the major teaching hospitals in Dublin. All the collective evidence available to the Scheme including radiology, medical records, inconclusive scar evidence, each applicant's personal statement and the case put forward on her behalf was put before the Scheme's three experts and Mr. Bowen-Simpkins<sup>60</sup>. Each expert had previously advised in his own field without being aware of the entirety of the evidence or of the other opinions. Each case which turned on its own facts and circumstances was individually presented by me to the four experts and was subjected to individual assessment by the experts and then to their collective view of whether symphysiotomy had been performed. In each case, the radiology was projected onto a screen and both the radiologist and pelvic surgeon presented their particular findings. The existing medical records were also projected on to the screen. When the collective opinion was declared, I acted on their advices.

#### **RETURN OF DOCUMENTS**

119. All applications and supporting documents are being returned to the applicants at their home addresses or to their assisting solicitors or are being confidentially shredded in accordance with wishes expressed.
120. We do not hold and have never held original records.

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<sup>60</sup> Mr. Bowen- Simpkins had frequently advised in applicants' litigation as an expert witness and was familiar with the terms of the Scheme.

## ASSESSMENTS

### CATEGORY 1A

121. 150 claims were made under 1A. If the symphysiotomy was established, the application was prioritised for early assessment as no further proof was required. By the end of January 2015, **82** of these claims had been assessed and the awards of €50,000 processed for payment. Whenever an examination of furnished documents suggested a possibility of significant disability might exist or that the claim should be assessed under another category, the claim was upgraded to the appropriate category and assessed under that heading so that further investigations could be conducted when the application reached its chronological place for assessment. **18** out of 150 applicants under 1A were upgraded to 1B or 1C for elective/prophylactic symphysiotomy.
122. Several applicants who claimed under 1A stated that they knew they had a difficult birth but were extremely grateful to have a lovely healthy baby. They were lucky that they *had not suffered like those other women they saw on the Primetime programme*.
123. **48** applicants under 1A did not undergo symphysiotomy at all and either withdrew their applications in acknowledgment of that fact when informed or were declared ineligible to receive an award. **1** applicant died before her case was assessed.
124. Ultimately, of the 150 claims made under 1A, **83** received an offer of €50,000.

## CATEGORY 1B – SIGNIFICANT DISABILITY

125. Once the qualifying symphysiotomy was established, any application for payment of €100,000 under 1B was further assessed to identify and then establish any significant disability defined under the terms of the Scheme as follows:

*“**significant disability**” means medically verifiable physical symptoms and/or conditions directly attributable to the surgical symphysiotomy or pubiotomy and which have had a serious and debilitating effect on the Applicant’s quality of life and include, but are not confined to, pelvic instability, pelvic pain, dyspareunia, urinary incontinence, back pain, pain on walking which continued for more than three years after the surgical symphysiotomy or pubiotomy.”*

126. The first step was to ascertain whether the applicant had identified the condition claimed to qualify as significant disability. All too often, it was asserted on behalf of the applicant that she had endured a *life time of pain, that she had a waddling gait, had difficulty walking, suffered back and hip pain, pelvic pain, pelvic instability, dyspareunia and urinary incontinence*. In fact, all of the conditions described as significant disability under the terms of the Scheme. It was left to us to examine the furnished records in the hope of finding some evidence to support those claimed conditions.

127. I was very conscious that almost all applicants were elderly and in some cases, extremely elderly<sup>61</sup>. It was obvious that these applicants would require a degree of acceleration in the treatment of their claims. All applicants born before 1930 were therefore prioritised for assessment. It was soon apparent that many of these elderly applicants had been profoundly influenced and affected by media reports of injuries allegedly sustained. Some were agitated by their involvement, at a late stage in their

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<sup>61</sup> More than 30 applicants have died since receiving their awards

lives, in High Court litigation<sup>62</sup>. They were treated very gently and with a great deal of sympathy and their claims were expedited.

128. Generally, applicants who claimed significant disability provided personal statements which were very similar in content to each other and which seemed to follow a definite template. They began with a young and happy woman who played tennis/camogie/ rode a bicycle, had a good job, had a wonderful intimate relationship with her husband until symphysiotomy was inflicted on her robbing her of her health, her fulfilling relationship with her husband and her capacity to enjoy life. Applicants clearly believed or had been led to believe that they had been mutilated and that their pelves<sup>63</sup> had been *sawn in half* and *broken in two or fractured*<sup>64</sup>. Despite the fact that no saw is ever used for a symphysiotomy, a large number of applicants claiming significant disability stated frequently that they would *never forget the sound of the saw*. The saw featured heavily in sensations described. Some applicants recalled actually seeing the doctor taking out the saw which was sometimes described as a *hacksaw* or an *electric saw* or a *saw with a wooden handle*.

129. The similarity between statements describing personal experiences was at first, quite understandable. There were after all many common features: generally the patients who underwent symphysiotomy were young and having their first baby. Most of them were small in stature and their baby quite big in comparison. Their labour was difficult, they had pain after the delivery, they were confined to bed with a catheter and were not permitted to get out of bed for several days. It was quite reasonable that they would recount a similar narrative. However the frequency with which the following was reported was unusual: “no-one told me what was happening..... .....I heard the sound of a saw and felt that I was being sawn in half.....I thought my baby was dead ....I had to learn to walk

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<sup>62</sup> Such notations appeared in many GP records

<sup>63</sup> plural of pelvis – there is a huge inconsistency in the use of latin and greek in medical terms and in the spelling of those words. The plural is also found as pelvises. We have observed the spelling of unborn baby as phoetus, foetus and the more current fetus.

<sup>64</sup> Several women told their medical advisers that they had been extremely upset by what they heard in the media and at meetings.

again.....I was forced to walk and collapsed.....I never bonded with my baby.....when I went home I couldn't manage and went to my mother's house..... sex with my husband was extremely painful .....I was turned overnight into an old woman.....I have been incontinent since..". The treating doctors and nurses were always depicted as uncaring and unkind; peremptory in manner and unwilling to inform. Often what the doctor said to the applicant before or after the symphysiotomy was identical in wording to what was said at St. Finbarr's in Cork or at the NMH in Dublin or the Lourdes in Drogheda. Symphysiotomy was sometimes attributed to doctors who were not there. In several statements the applicant claimed being held down by nuns (in hospitals where there were no nuns) while she was being *assaulted*.

130. These were harrowing stories indeed. Unfortunately, their currency was somewhat devalued by the degree of similarity in so many histories including as was soon learned, in the narratives of the many applicants who did not undergo symphysiotomy. It was noted that statements were sometimes written in a hand that differed from the applicant's signature. Some statements which were handwritten were followed by a typed version using more forceful language and providing enhanced details of the ordeal immediately after the symphysiotomy.

131. Many of those women who made personal applications simply said that they thought the pain afterwards was normal and never made an issue over it. A very odd feature was that few applicants who provided graphic accounts of the symphysiotomy referred to their next or subsequent pregnancies at all nor did they refer to how they managed to raise their families, in many cases, quite large families with more than 6 children. There was often a jump in the chronicle from the period following the symphysiotomy to their current condition; frequently a period of more than 50 years. There were many lurid accounts with very little difference between the recollections of those who had actually undergone symphysiotomy and those who merely believed that they had. A common

feature was that they had been *assaulted* and that the procedure was performed *without justification or consent*. There seemed to be a great amount of anger in the personal statements as most applicants claimed that they should have been delivered by caesarean section and that the symphysiotomy was *unwarranted*.

132. The Scheme was specifically tasked to address the group of women who had undergone symphysiotomy so many years ago. Any misgivings or scepticism was therefore set aside and any exaggerated recollections were viewed as understandable confusion between reality and acquired group memory. Objective findings contained in contemporaneous medical records and from radiology were relied upon. A low bar on the balance of probabilities was applied to significant disability. Once symphysiotomy was established, a compassionate and generous view was applied to the assessment of each claim.
133. Examination of records found that 30% of applicants did not undergo symphysiotomy at all and most applicants did not suffer medically verified injury which accorded either with media reports or with their narratives. This overall finding is reflected in the number of applicants (30%) who underwent symphysiotomy but did not claim any disability. My own expectation at the commencement of the Scheme that most applicants would be able to identify and establish their significant disability was not confirmed.
134. However, once a sympathetic low threshold was applied, 142 applicants were assessed as having suffered significant disability and received appropriate awards. The bar had to be reduced from **directly attributable** to symphysiotomy to a **possible association** with the symphysiotomy. Wide diastasis, the condition of the pubic joint and accompanying sacroiliac joint disease were among the few findings which could be objectively connected to the symphysiotomy.

135. I was ultimately glad that most exaggerated accounts were ignored and compassion was applied to these women who perhaps were influenced by others to make the statements. This led to some of the more pleasurable moments as judicial assessor when I read the warm letters and notes from the women who wrote to me after they received their awards to tell me that they were certainly intent on spoiling themselves a little. Several very happy applicants rang to tell me how they were going to spend their money. One lady was buying a special hat. One applicant lifted my heart when she told me that she had never had any money in her savings account. Now she looked at her bank account every morning, for the sheer pleasure of seeing the amount of money in the account in her own name. One delightful applicant invited me to tea at her house and one wrote a poem of appreciation. Most women who wrote, told me that it gave them huge pleasure to be able to help their children or their grandchildren with their awards.

**THE MAJOR FINDINGS MADE OF SIGNIFICANT DISABILITY WERE:-**

- wide diastasis
  - wide diastasis and co-morbidities
- pubic joint abnormality and related pain
- pelvic instability
- incontinence
  - urinary incontinence and urinary tract infection
  - the Lourdes Hospital and incontinence claims
- psychological/psychosexual difficulties
- sacroiliac abnormality and related pain
- miscellaneous



## **WIDE DIASTASIS**

136. The pubic symphysis is a 10mm disc made of fibrous cartilage, which separates the pair of pubic bones (pubic rami) situated on either side. It is made of relatively soft material which softens further and stretches naturally during pregnancy. The purpose of the symphysiotomy operation is to separate the disc in order to widen the internal dimensions of a narrow pelvis to permit vaginal delivery of the baby whose progress is otherwise impeded in that and subsequent pregnancies. The disc is initially separated to the width of approximately two fingers.
137. In many cases, the separated pubic symphysis had reunited leaving little or no evidence of its previous divided state. As no periodic radiological studies were conducted on any of the applicants, it is impossible to say when this joint approximation occurred. It can only be speculated that it was when childbearing was complete. In others, the widening was still visible but the separation was generally very considerably smaller than the original 2 finger width. I was concerned to learn whether this separation between 15mm and 39mm in 63 cases caused pelvic instability as was claimed in so many medical reports furnished by applicants.
138. I am advised that the stability of the pelvis is dependent on bony and ligamentous components and not on the pubic symphysis. Disruption of part or whole of the pubic symphysis does not necessarily result in pelvic instability as not every disruption to the pelvic ring causes instability. For example, pubic rami fractures are stable injuries which do not affect stability. The posterior ligaments of the pelvis, the sacrotuberous and sacrospinous ligaments which are not affected by symphysiotomy, contribute significantly to pelvic stability, principally in relation to vertical stability but also to rotational stability. In any event, any division of the pubic symphysis is temporary as the division heals quickly. The concept of pelvic instability, if such condition is considered to occur with the

separation of the disc, and its application to surgical symphysiotomy is a remote possibility and not a given.

139. I am advised by the Scheme's medical experts that comparing surgical symphysiotomy with pelvic fractures (which require a very great crushing or shearing force and which do cause pelvic instability in the immediate aftermath when bones are displaced) and disruption of the pelvic ring is an inappropriate and invalid comparison.

140. They explain that symphysiotomy widens the internal dimensions of the pelvic inlet to allow the arrested baby's head to pass through the brim and outlet. However the important extra widening of up to 1 inch is within the pelvic inlet at the ischial spines rather than solely at the brim. It is therefore not correct to equate the division of the cartilagenous disc, which acts as a buffer between the end of the pelvic bones as opening a book or as an open book injury. It is incorrect as the book which is opened still remains within its wrapping of muscles and strong ligaments. It is too simplistic to describe the symphysiotomy procedure as unhinging the pelvis as that is a description more appropriate to an act on a skeleton which is devoid of its retaining ligaments. The appropriate analogy is perhaps the slight opening of the book to let an enclosed letter slip out. If the book is the equivalent of the pelvic ring, then it is only opened slightly and the binding is not damaged.

141. The assessments concentrated on the cases of the 63 or almost 16% of applicants where radiology showed a continuing joint separation of between 15mm (just over half an inch) to 40mm (just under 1.5"). As previously outlined in the chapter on radiology, it is not possible to say whether a degree of continuing separation of the pubic symphysis made or makes any real physiological difference as there is fibrous union between each half. In most cases, the diastasis was a condition found on x-ray rather than from complaints made by applicants themselves. It was observed that according to recent GP records provided, a significant

number of this group with wide diastasis appeared to be leading full and healthy lives where golf, hill walking, dancing, travelling, gardening and even farming were/are enjoyed. Many women in this group raised large families and then engaged in paid employment outside the home. Catering work which involves pushing and carrying and being on one's feet featured strongly as did office and hospital cleaning.

142. It is therefore unclear what adverse effects on current daily life follow a finding of a wide diastasis. Either bridging fibrous union mends the void or, as the orthopedic specialists assisting the Scheme advise, the strong ligaments in the pelvis provide stability while the joint is repairing. Once fibrous union has occurred at 6-12 weeks, the pelvis is restored. It is also possible that the body's incredible ability to accommodate to insult, ensures a recovery. Whatever bio-mechanics come into play, it seems that many women can lead normal lives notwithstanding the radiology findings of wide diastasis.

#### **WIDE DIASTASIS AND CO-MORBIDITIES**

143. 19 cases of wide diastasis showed associated sacroiliac arthropathy but 44 applicants with wide diastasis demonstrated sacroiliac joints which were normal for age. Some applicants who had significant sacroiliac joint arthropathy had no diastasis. No conclusion could be made that symphysiotomy patients had a predisposition to suffer sacroiliitis either with or without wide diastasis. Some applicants with a wide diastasis complained of back pain and incontinence. Others did not. There was no pattern of co-morbidities with a wide diastasis. However, as a finding of wide diastasis was sufficient to find significant disability, these further complaints were not investigated.
144. My understanding is that the incidence of significant sacroiliac joint arthropathy in the general population aged more than 75 years is approximately 10%. The findings among the applicants whose radiology

was seen does not show a figure that differs significantly from that of the general population of the same age.

145. The chapter on Radiology provides the Table of wide diastasis cases and whether those applicants had sacroiliac joints that were either normal for age or abnormal and should be read with this chapter. Wide diastasis appears to be a finding peculiar to symphysiotomy. It is an objective finding. The surprise was not the 63 cases with continuing separation of the disc but the fact that the rest of the cases showed joint approximation.

#### **PUBIC JOINT ABNORMALITY AND RELATED PAIN**

146. Pubic/pelvic pain following symphysiotomy is completely understandable in the recovery stages. I am informed that surgical symphysiotomy is a more painful procedure than modern caesarean section and that the recovery period is longer<sup>65</sup>. My information came directly from those obstetricians who have regularly carried out symphysiotomy. As vertical incisions for caesarean section have for the most part been replaced by pfannenstiel or bikini line horizontal incisions, we were unable to assess the difference between post symphysiotomy pain and pain from older larger vertical incisions of the 1940s, 1950s and 1960s. The recognition of pain associated with symphysiotomy is confirmed by post natal drug charts which show that strong analgesia was routinely prescribed following the surgery as were sleeping pills. We had however no way of knowing whether patients were prescribed pain killers by their GPs following their discharge from hospital.
147. A small number of applicants claimed continuing pubic pain long after the expected recovery period. Such pain so many years after the event required explanation. Radiology provided objective explanations for some of the complaints. Approximately 12 applicants showed what Professor

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<sup>65</sup> Professor Glen Mola and current literature on symphysiotomy written by obstetricians who actually perform the procedure.

Lawler described as a grossly abnormal pubic joint. He explained that many elderly persons develop sclerotic changes and possibly some osteophytosis at the pubic joint as part of the ageing process. Those with a grossly abnormal pubic joint demonstrated findings that went beyond these age related conditions and were not found in the normal population. In fact, this imaging of the pubic joint caused me to question whether this condition with its series of abnormal findings was possibly the single longterm adverse sequela of symphysiotomy.<sup>66</sup> Once this condition was reported, it was accepted as evidence of medically verified significant disability. This was the situation even where the joint had approximated and includes all cases where the following were identified:

- Large osteophytes (bony spurs associated with degeneration of a joint)
- Vertical misalignment or translation
- Corticated bone fragments
- Flamboyant sclerosis of the pubic joint
- Evidence of inflammation associated with past movement

148. We noted that haematoma and wound infection were described as morbidities in several instances in the Annual Clinical Reports. On other occasions the surgeon reported that a pubic ramus were hit by the scalpel in an effort to locate the disc and no doubt when the operator was sometimes working in emergency conditions and either missed or overseparated the symphyseal joint. I am advised<sup>67</sup> that these morbidities could be the reason for some of the conditions found on radiology and explain the complaints of pain extending beyond the normal recovery period. Each of the conditions found on radiology could explain why some applicants suffered continuing pain during sexual relations, sensitivity at the joint or a feeling of grinding in the joint when rising from a sitting position or when climbing stairs long after the normal recovery period. In

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<sup>66</sup> Very few medical histories demonstrated complaints, investigations or treatments which were commensurate with the radiology

<sup>67</sup> By Professor Glen Mola

all those cases, there was objective and clear radiological evidence supportive of a protracted period of recovery and in some cases, continuing discomfort.

149. Joint abnormality also led to the inference that there may have been some associated minor bony injury or infection at the time of the symphysiotomy which contributed to inflammation or osteitis pubis in the joint. This, I am advised gives rise to more pain for a longer period following the procedure.

150. Some degree of pelvic joint abnormality was seen in 24 cases although the number with “gross joint abnormality” was 12. The gross abnormality findings included 4 cases where large osteophytes were found which explained continuing pubic sensitivity and pain during sexual intimacy in those 4 cases. In 8 cases, there also was a diastasis of more than 15mm. 3 applicants with grossly abnormal joints had a diastasis of between 25 and 35mm. 2 applicants had a translation of more than 10mm which I am told is radiologically more significant than a wide diastasis. In 6 other cases there were either corticated bone fragments or corticated bone. All cases with bone fragments showed other abnormal findings. In 5 cases there was evidence of either cancer treatment<sup>68</sup>, fracture from an injury sustained long after the symphysiotomy or recent osteitis pubis. These issues complicated the findings but significant disability was found on the basis of a wide diastasis..

151. The condition of the pubic joint in each of the 24 cases permitted me to assume that these applicants suffered pelvic pain or pubic pain which may have contributed to dyspareunia and its associated interpersonal difficulties including marital breakdown and/or fear of further pregnancy.

152. Several claimants made very similar claims of pubic sensitivity but their radiology was absolutely normal with nothing demonstrated which could

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<sup>68</sup> I am advised that radium treatment of the pelvic area affects the condition of the bones and joints

indicate any surgical interference whether by way of sclerosis, inflammation, osteophytosis, translation or diastasis. If they had several children post symphysiotomy or their medical records showed no evidence of complaints, treatments or investigations for that pubic pain, then no significant disability under that heading was found.

153. Pelvic pain or pubic pain contributing to dyspareunia was assumed in every case where abnormal pubic joint was found.<sup>69</sup> Pubic pain was found in a small number of other cases where radiology was not abnormal but where a series of other facts permitted me to treat their cases with a wide margin of sympathy and the benefit of the doubt.

154. Some applicants who complained of current pelvic pain wished to make a connection with symphysiotomy. Radiology showed age related stress/insufficiency fractures which could explain late developing pain. Their particular medical notes indicated that they had been involved in falls, road traffic accidents, work related or leisure incidents in the period since the surgical symphysiotomy. In some other cases recent osteitis pubis was seen. These injuries were considered to be unrelated temporally to the symphysiotomy procedure.

#### **PELVIC INSTABILITY**

155. The Scheme's medical advisors had difficulty in understanding what exactly *pelvic instability* meant in the context of surgical symphysiotomy<sup>70</sup>. That said, 6 applicants among the 12 cases of grossly abnormal pubic symphysis joint showed evidence of some past movement in the pubic joint following symphysiotomy. The findings in 2 cases were complicated by radium treatment for pelvic cancers but showed significant diastasis and other unusual findings. In 3 other grossly abnormal joints, there was a diastasis 27mm, 32mm and 35 mm. Although the pubic symphysis was now stable, there was radiological evidence of past movement in the joint

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<sup>69</sup> 4 women of low parity had no further children following the symphysiotomy birth.

<sup>70</sup> Professor Lawler has written his analysis of all radiology seen which is Appendix 1.

in each of those cases with evidence of old inflammation and otherwise abnormal repair of the pubic joint. The advice was that the movement in the past would very likely have contributed to joint pain at the time. There was no movement now.

156. In 1 case, there was evidence of current movement in the pubic joint. This is the only case of what could possibly be described as pelvic instability. In all 6 cases where there was evidence of movement in the joint, the sacroiliac joints were considered normal for age.

157. Of interest and perhaps validation of advice received from the Scheme's experts when dealing with pelvic pain and with back pain assessments was my meeting in July this year with Professor Glen Mola. We met in the headquarters of the RCOG while I was researching the archives for this report. Prof. Mola who is Australian is a very experienced symphysiotomist and is the lead obstetrician at Port Moresby University Hospital where more than 18,000 babies were delivered last year. He currently performs about one symphysiotomy a month while he performs 3 caesarean section on most days. He confines symphysiotomy uniquely to cases of failed vacuum extraction. The patients are mostly very young and having their first baby. As a rule, he does not perform symphysiotomy on any mothers over 35. Other obstetricians in outlying stations are trained to perform symphysiotomy when the emergency field hospital which provides full facilities for caesarean section cannot make the patient in time.

158. We discussed the cases of abnormal radiology findings of the pubic symphysis. He explained that the grossly abnormal findings identified by Professor Lawler were very likely caused when the symphysiotomy scalpel made contact with the periostium (the membrane covering over the outer surface of bones) of the adjacent pubic bones or when the knife penetrated the bone itself. This inadvertant contact can set up an inflammatory reaction known as osteitis pubis which causes significant temporary pain. He explained that as the cartilage which separates the



pubic bones is only 1cm across, it is essential for the surgeon to identify the disc and then to aim for the middle where there is a fluid filled hollow area and only then separate the fibres at that point. He advised that an inexperienced operator faced with an emergency could very easily allow his scalpel to wander to the left or right and inflict some small scratch damage to the pubic bones. His view was that the inflammation was of no real long term consequence but would explain the abnormal radiology findings and additional pain suffered following the procedure. The deviation of the surgical knife towards the pubic rami was in his opinion the very likely cause of some of the radiology findings of large osteophytes, capsular hypertrophy, small bone fragments and flamboyant sclerosis which had been found in approximately 12 cases. He advised that osteitis pubis could significantly delay the full recovery process which was normally about 3 months to more than 6 months. Haematoma could calcify and contribute to a continuing wide diastasis. He also advised that returning to heavy lifting and becoming pregnant before the joint recovered could all contribute to a slower recovery.

159. In Port Moresby, they do not bind their symphysiotomy patients but confine them to bed lying on their side until the indwelling catheter is removed – usually on the second or third day. There was usually a degree of urinary incontinence following removal of the catheter but this soon settled down. The patients began ambulating on a frame as soon as they felt up to it. The patients were usually very keen to attend personally to their toilet needs as soon as the catheter was removed and were very inclined to try walking or hobbling at this early stage. Almost all his patients were walking well by the 10<sup>th</sup> or 12<sup>th</sup> day and were fully recovered in 3 months. The technique was always by the sub-cutaneous method requiring only one suture for closure of the wound. Long term disability was very rare indeed in his experience

## **INCONTINENCE**

## **URINARY INCONTINENCE AND URINARY TRACT INFECTION**

160. Incontinence was without doubt the condition which was most frequently claimed and the least established disability as defined by the terms of the Scheme. Most applicants who claimed incontinence had also issued proceedings seeking damages for personal injury arising out of the symphysiotomy performed on them. Most of the pleadings included claims that the plaintiff had suffered damage to the urethra and bladder and suffered ongoing urinary incontinence<sup>71</sup>. The clear impression is that many advisers – medical as well as legal - associate surgical symphysiotomy with urinary incontinence due to inevitable urethral and bladder damage. An odd observation was that most applicants who presented their claims personally did not make the case that they suffered from incontinence.

161. Advice in the field of uro-gynaecology was sought to explain the causation or association between symphysiotomy and urinary problems and why, if such problems existed, was there no mention of the condition in medical records or notes until the applicant was elderly. Incontinence directly attributable to symphysiotomy and sufficient to constitute *a serious and debilitating effect on the applicant's quality of life* is not something which can be ignored by doctors or nurses when a patient is in hospital. Mild stress incontinence can be discretely managed but incontinence of the type claimed is obvious and requires treatment.

162. I was advised<sup>72</sup> that it was first necessary to understand some facts about urinary incontinence in women generally as a degree of stress incontinence and/or frequency is a biological process which can and does occur during pregnancy and after childbirth. Frequency and stress incontinence in the later stages of pregnancy as the gravid uterus weighs on the bladder are also common conditions. Incontinence is a problem encountered even with the most modern practices in state of the art delivery suites throughout the developed world. This is especially so with heavier babies and following multiple vaginal deliveries.

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<sup>71</sup> A sample of those pleadings is found at the end of this chapter

<sup>72</sup> Dr. McKenna, Dr. O'Reilly, Prof. Dornan, Mr. Smith

163. High parity is no longer the norm in Ireland and prolonged or obstructed labour is a rare occurrence but nevertheless, stress incontinence remains common after vaginal birth. As evidence of this, a well attended incontinence clinic with specially qualified physiotherapists and urogynaecologists is attached to every maternity unit in Dublin. The primary treatment is education in pelvic floor strengthening exercises and weight reduction. Another example of the extent of stress incontinence issues is the frequent television advertising at prime time of disposable underwear designed to cope with urinary leaking for women suffering from an overactive or sensitive bladder (a euphemism for stress incontinence).
164. I am advised that stress incontinence occurs even in young women who have never been pregnant and in women who have never faced a protracted labour. I was referred to several recent studies on incontinence in Ireland, the UK, Norway and Sweden. The studies outline the frequency with which a degree of stress incontinence occurs in women.
165. In the MAMMI<sup>73</sup> ongoing study conducted by the Midwifery School at TCD, it was found that more than 1 in 5 participants (women who had delivered in the previous 12 months) experienced some degree of urinary incontinence before pregnancy and that almost 1 in 3 participants experienced some degree of urinary incontinence at the start of pregnancy which continued during pregnancy. Three months after delivery, 1 in 2 women leaked some amount of urine and even 6 months after the birth, 1 in 5 women still leaked urine once a month or more frequently. Stress Urinary Incontinence (SUI) was defined as involuntary leakage on effort or exertion, or on sneezing or coughing.
166. A very recent study in Sweden examined a large cohort of women who had each given birth to just one baby. When those women were reviewed 20 years later, 40% of them were found to suffer from a degree of pelvic

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<sup>73</sup> Mothers Health And Maternal Morbidity in Ireland

floor dysfunction (prolapse or urinary incontinence). All studies to which I was directed point in one direction: stress incontinence is common after childbirth and is present even in women who have never been pregnant<sup>74</sup>.

167. I am advised that while there are many theories for why post-partum stress incontinence occurs, no preventable cure exists apart from awareness of exacerbating factors being maternal age at the time of delivery, the baby's weight, the mother's body mass index, family history of incontinence and being alert to the value of pelvic floor exercises. Bladder dysfunction is also a significant issue with increasing use of epidurals. Uro-gynaecological problems increase with each vaginal delivery, with age, by smoking (because of coughing), by withdrawal of estrogen (menopause) and by being overweight. The incidence of stress incontinence therefore rises with parity and especially with bigger babies and in post-menopausal women **even** when the deliveries have been by caesarean section. Frequency, urge incontinence and pelvic organ prolapse are unfortunately common post-menopausal conditions which worsen with age and can be associated with diabetes and anti-hypertensive medication. The vast majority of incontinence sufferers have never undergone symphysiotomy.

168. The separate association of symphysiotomy with incontinence probably comes from the fact that most such procedures were carried out in the second stage of labour<sup>75</sup> on young first time mothers (primigravida). At that time in the development of obstetrics, intervention by caesarean section was reserved for life threatening conditions. From the 1940s to the early 1960s, when symphysiotomy was in its apogee and was practiced in the major maternity hospitals in Ireland, the concept of active management of labour had yet to be invented. Most first time mothers therefore endured long and painful labours with only strong opiates (pethidine) to relieve their

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<sup>74</sup> Report UR\_CHOICE : *Can we provide mothers-to-be with information about the risk of future pelvic floor dysfunction?* Don Wilson, James Dornan, Ian Milsom and Robert Freeman *Int Urology J* 17April 2014

<sup>75</sup> This excludes many earlier symphysiotomy procedures which were carried out in advance of labour and those carried out after caesarean section.

distress<sup>76</sup>. The labour proceeded to delivery, no matter how prolonged, unless the baby's well being was compromised (fetal distress) or the mother was exhausted (maternal distress) or both. In most cases, even where there was a tight fit, the baby delivered naturally without resort to symphysiotomy or caesarean section. However, it was often necessary to use forceps to effect delivery because the exhausted mother could make little more effort (uterine inertia). This was the norm throughout the world and may go some way to explaining why so many applicants who were first time mothers acquired the mistaken belief that they had experienced symphysiotomy.

169. Prolonged labour was not uncommon for primigravid patients before Dr. Kieran O'Driscoll's<sup>77</sup> new protocols on predetermining a fixed length of labour, an individual regime of personal care for each mother and generous use of oxytocin were received and became the norm. He has written that when he became the Master at the NMH in 1963, he was concerned that the experience of protracted and painful labours in first time mothers often produced such an aversion to further pregnancy in those mothers that many of them became *voluntarily infertile*. This he believed brought obstetrics into disrepute and should be prevented. He determined that labour should not be left to take its course and means should be found to ensure that giving birth should not be such an unpleasant experience. O'Driscoll's experiments to reduce the acceptable length of labour for first time mothers resulted in setting limits first to 36 hours and then 24 hours and eventually to 12 hours by 1968/69. His ideas received much acclaim in Ireland in the late 1960s and the UK in 1972<sup>78</sup> and eventually became the norm in modern obstetric practice.

170. Before these changes became common practice, the few mothers who underwent (usually emergency) symphysiotomy had already gone through a trial of labour. They then faced the additional risks associated with the

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<sup>76</sup> The use of pethidine often relieved the pain but prolonged the labour sometimes leading to lack of maternal effort or uterine inertia

<sup>77</sup> Introduced by him in the NMH while he was Master and eventually adopted worldwide.

<sup>78</sup> BMJ 1973

use of a scalpel (as can occur in all surgery) and the removal of symphyseal support for the walls of the vagina. It is therefore understandable that a degree of incontinence could occur in that group of mothers. The problem for the Scheme was to distinguish stress incontinence **associated** with normal pregnancy from incontinence **caused by** symphysiotomy.

171. Several applicants provided statements describing *urine running down their legs from the day of the symphysiotomy*. This form of incontinence is consistent only with fistula.

172. Vesico-vaginal fistula has certainly been associated with symphysiotomy in literature on the subject. In fact, there is no scarcity of literature which recounts the earliest recorded symphysiotomy operations in the 17<sup>th</sup> and 18<sup>th</sup> century when previously lost babies were saved and mothers survived - if they were lucky - but suffered from lifelong fistula<sup>79</sup>. While results from symphysiotomy may have improved in the late 19<sup>th</sup> century and early 20<sup>th</sup> century, the major morbidities contributing to the abandonment of the procedure in the 1920s were undoubtedly incontinence arising from urethral and bladder injuries and mobility problems due to overstretching of the sacroiliac joints. With the demise of prolonged labour, obstetric fistulae almost disappeared from maternity units. However, it was a real risk in the 1940s and 50s both from prolonged labour and from a cut to the bladder or overstretching of the urethra during symphysiotomy<sup>80</sup>.

173. I am advised that a fistula forms when labour has lasted more than 24 hours with the baby's head pressed against the vagina wall or the bladder. The tissue in the bladder or vagina is neurologically compromised and breaks down to such extent that a hole is formed allowing urine to leak directly from the bladder into the vagina. The fistula is not actually caused

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<sup>79</sup> Symphysiotomy per se does not cause fistula. It is caused by the pressure of the fetal head on the vagina and bladder/urethra in obstructed labour. See below for further explanation on fistula.

<sup>80</sup> It can also occur in urological and gynaecological surgery and in caesarean section

by symphysiotomy but is associated with prolonged labour, the very circumstances in which symphysiotomy was usually performed.

174. As mentioned, a fistula involves urine escaping through a hole in the urethra or bladder into the vagina. The normal sphincter muscles in the urethra are bypassed and the patient loses urinary control. The degree of escape depends on the extent of the fistula. Some very small fistulae are repaired by cauterization or heal up themselves but a larger fistula must be surgically repaired. Most fistulae occurring during labour can be successfully repaired.

175. An untreated fistula requires the wearing of adult incontinence nappies and protective bedding. It is a very unpleasant and distressing condition which cannot possibly escape detection. Neither the patient nor her medical attendants could be unaware of the condition as it is associated with huge social inconvenience, excoriation of the labia and mostly with an inescapable odour and staining by adult urine. We found no evidence that any applicant suffered from an untreated fistula.

176. Clearly, there is a wide distinction between incontinence caused by fistula which was rare even in the 1940s and 50s and the type of mild urinary leaking associated with pregnancy and childbirth, which is common. In between the two extremes are urethral tears or small nicks to the bladder. Fistula is the most serious form of obstetrical urinary incontinence.

177. With all that information in mind, we examined the individual claims made. This involved looking back through records of 50 or 60 or more years ago to determine whether incontinence following symphysiotomy was noted. We examined the following source documents when they were available:

- the delivery records;
- annual clinical reports;
- ante-natal care notes;
- the notes relating to the next and subsequent pregnancies;

- GP notes;
- medical records of subsequent surgical procedures;
- treating gynaecologists' notations on medical examinations;
- the opinions of treating urologists or urogynaecologists.

178. I considered it reasonable to expect that notations of stress incontinence would be found in delivery records, in post natal care notes, the notes relating to the next and subsequent pregnancies and in GP records. It would be reasonable to expect that there would be medical records of subsequent surgical procedures by urogynaecology specialists with notes of treatment close to the time of the symphysiotomy. This was not the case. In particular, there was no evidence of any applicant leaving the hospital with urine running down her legs. The 4 urinary fistulae identified among the claimants were recognised and repaired before discharge or soon after. One other case involved a feeling of dampness which repaired itself after a few weeks.

179. I first determined that the test for finding incontinence constituting significant disability would be evidence of *any* mention of *any* degree of incontinence or urinary tract infections on the available notes relating to the symphysiotomy birth and the next pregnancy. The cases were so few that the threshold was lowered again to any mention of incontinence or multiple urinary tract infections in GP records in the first decade following the symphysiotomy birth. Even when the threshold was set at the low level of any possible temporal association with symphysiotomy, little was found to match complaints in the majority of cases. Examination showed that if a patient had suffered any iatrogenic injury at the time of symphysiotomy in the Dublin hospitals or at the Lourdes hospital, those injuries or morbidities or adverse events were recorded and readily identified in the Clinical Reports<sup>81</sup>. There was a clear written trail of identification, treatment and outcome recorded. Incontinence was always noted.

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<sup>81</sup> Charts were available from most hospitals from 1968. Unfortunately with the passage of time, the only hospital with Clinical Reports as well as almost full clinical charts was the Lourdes Hospital. There we had the benefit of contemporaneous records and the Clinical Reports.



180. GP records showed that a number of applicants do indeed currently suffer stress and/or urge incontinence or frequency or in some cases, more severe urinary conditions such as chronic UTIs. Reference to these conditions was found in more recent records but generally they were absent from earlier records. It was particularly noted that references to leaking, stress and/or urge incontinence often appeared for the first time in temporal association with hysterectomy carried out several decades after the symphysiotomy. In fact, hysterectomy was generally an extremely common procedure in this cohort of older women. I am advised that hysterectomy was commonly performed for menstrual dysfunction and prolapse before minimally invasive and medical management of those conditions became available in more modern times. It was also noted that many applicants with current urinary incontinence were women of high parity who are at particularly high risk of uterovaginal prolapse. It was noted that many had in fact undergone prolapse repairs and incontinence procedures. I was advised that this incontinence is not associated with symphysiotomy.
181. While evidence of incontinence which was very loosely associated with symphysiotomy was found in 24 cases, it was notably absent in the majority of claims. I could only wonder whether the passage of time had dulled memory of detail to such an extent that applicants either attributed mild post natal stress incontinence to symphysiotomy or confused post menopausal conditions with post symphysiotomy recovery.
182. I contacted the two urology experts who had been engaged by the HSE in Cork and Dublin in 2004 and 2005 to identify the medical needs of women who had undergone symphysiotomy. I was concerned at the lack of evidential support for so many claims of urinary incontinence to the Scheme and wondered if their experience had been different. Both experts informed that very few of the women who they saw actually suffered from
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incontinence. The women who did, were advised by them that as the condition first manifested decades after the symphysiotomy, it was associated with parity and age and not with symphysiotomy. The women who did have a degree of incontinence were referred to physiotherapy and pelvic floor exercises and did not require surgery. Following on from their advices, stress incontinence, nocturia and frequency developing many decades after the symphysiotomy were deemed not to be symphysiotomy related.

183. Ultimately, 24 applicants were found to have suffered significant injury associated with incontinence and urinary tract infections<sup>82</sup>. Only 5 applicants suffered from incontinence and/or urinary tract infections clearly attributable to **fistula, urethral or bladder damage** at the time of symphysiotomy<sup>83</sup>. In each case, we found that the conditions were recorded soon after the symphysiotomy and could readily be associated with the procedure. In those 5 cases, investigations and repairs and modalities of treatment had followed the incontinence and were recorded<sup>84</sup>. It was noted that some applicants with wide diastasis had multiple morbidities. For instance 5 of the applicants who had urinary incontinence also had a wide diastasis and in 3 cases they had sacroiliac arthropathies with urinary issues.

184. None of the remaining 19 applicants who received awards for incontinence suffered from fistulae or urethral or bladder damage but were identified as suffering from stress incontinence or chronic urinary tract infections dating from the first 10 years following the symphysiotomy. All their further pregnancies and deliveries following the symphysiotomy were ignored for the purposes of assessment. The fact of very large babies or the use of forceps was not considered. As mentioned above, the bar was set low and no consideration was given to naturally occurring pregnancy related stress

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<sup>82</sup> I am advised that most women experience UTIs at some stage in their life and many of these women develop chronic urinary tract infections without ever having undergone symphysiotomy.

<sup>83</sup> These claims came from St. Kevin's Hospital, Galway General, NMH, Portiuncula and St. Finbarr's

<sup>84</sup> In one case, the applicant's award followed an interview as birth records were not available.

incontinence once urinary problems were found in near temporal proximity to the procedure. For the purposes of the Scheme, stress incontinence and UTIs in the first decade were attributed to symphysiotomy.

#### **THE LOURDES HOSPITAL AND INCONTINENCE CLAIMS**

185. Many applicants claimed incontinence attributed to symphysiotomy performed at the Lourdes Hospital. This was the hospital where the largest number of claims originated. As mentioned previously, a full set of clinical records was available from the maternity unit in that hospital. It was therefore a simple matter to examine applicants' patient charts. It was seen that the record keeping in this hospital followed a pattern. The first page of the chart recorded the patient's personal information and provided details of each delivery in provided columns. There was one delivery per column. The mode of delivery was clearly noted and symphysiotomy stood out immediately. All clinical and nursing notes were retained in the same file behind the personal information and delivery history. The entire maternity record for the first and all subsequent pregnancies was repeated on the second page. Pre-printed pages were completed for each stage of each pregnancy. Ante-natal conditions were listed on the top of standard obstetric sheets. If the patient suffered from any of the outlined complaints which included incontinence and back ache, the condition was underlined. The ante-natal attendances recorded her weight, BP, urine analysis and any health problems. Each birth involving symphysiotomy had the word symphysiotomy written in large letters across the labour record and appeared on the baby's care chart. There was generally a note on the delivery record by the attending consultant stating the reason for the symphysiotomy. The drug chart noted all drugs prescribed and given. The regime for post symphysiotomy patients routinely included anti-biotics and

strong analgesia while the patient was in hospital. Any patient complaints were noted.

186. The practice in the Lourdes Hospital was to record the patient's condition when she was being discharged following the symphysiotomy birth. The comments box on the patient's condition commonly included the descriptions *good, convalescent, no urinary or ambulation difficulties*. On occasion, *painful over wound or oozing from wound, pyrexia, sore back or UTI* was recorded. There was then provision for notes on the mother's condition at the 6 week check up. The vast majority of records noted no difficulties at the post natal visit.

187. There was a strong divergence between the contemporaneous records and memories and complaints as outlined in applicants' statements or complaints made on their behalf. In all but a tiny proportion, there was nothing on the records to confirm the relationship between symphysiotomy and the claimed stress incontinence or more general urinary incontinence. The patient charts usually contained the records for all subsequent births. There were very few reports of incontinence on those records. In fact, in several instances, when subsequent delivery records were examined, they actually disproved the claims of incontinence that had been made<sup>85</sup>.

188. In a small number of cases the relationship was established when *incontinence since symphysiotomy* or *first delivery* was found on the records of subsequent deliveries. In other cases, stress incontinence and/or a history of frequent urinary tract infections was documented in GP records which dated from the decade after the symphysiotomy. In almost all of those cases, the patient had been referred to a genito-urinary specialist long before the media reports of symphysiotomy appeared.

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<sup>85</sup> Of particular note were a couple of applicants who were in-patients for considerable periods in subsequent pregnancies. Daily observations recorded on their records refuted any claims of incontinence.

189. The 24 cases of urinary incontinence associated with symphysiotomy came from:-

- Cork hospitals 6
- Coombe 3
- NMH 3
- Lourdes Hospital 5
- Other hospitals 7

190. There was very little objective evidence that symphysiotomy caused significant incontinence.

#### **PSYCHOLOGICAL / PSYCHOSEXUAL DIFFICULTIES**

191. No claim for depression directly attributable to symphysiotomy was established. However there were some applicants who clearly suffered from a degree of anxiety which pre-dated the symphysiotomy and were therefore ill-equipped to deal with any abnormal delivery or obstetric emergency. A small number of applicants lost their baby at the time of symphysiotomy<sup>86</sup>. Some babies suffered from congenital defects which were incompatible with life and others were stillborn. A particularly low threshold for finding significant disability was applied to those cases. Some applicants suffered from an exacerbation of anxiety when hearing and reading about the effects of symphysiotomy.

- 7 applicants were categorised as suffering solely from psychological problems associated with the symphysiotomy procedure and received awards based on that condition.
- 6 applicants were categorised as suffering solely from psychosexual difficulties associated with the symphyiotomy procedure and received awards based on that condition.

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<sup>86</sup> The practice at the time seemed to be to conceal any gross congenital fetal abnormalities from the mother. Several mothers therefore continued to grieve for the baby who they believed was perfectly formed but stillborn. In this group were babies who were hydrocephalic and anacephalic.

## **SACROILIAC JOINT ABNORMALITY AND RELATED PAIN**

192. Complaints of back pain were very frequently made. Back pain is suffered to a greater or lesser degree by most people at some time and especially in an ageing population. My function was to determine whether these complaints were in any way medically verified and attributable to symphysiotomy. Those applicants who demonstrated that they underwent investigations for back pain shortly after the symphysiotomy were considered to have provided objective medical evidence of significant disability directly attributable to the symphysiotomy. Similarly, this assessment was made for those applicants who had a documented history of low back pain before and during the pregnancy which culminated in symphysiotomy. The assumption was made that their back condition was exacerbated by symphysiotomy once the temporal link was made. In 2 cases, it was noted that the applicant complained of increased back pain during the next pregnancy.
193. Those applicants who had a continuing wide diastasis were for the purposes of the Scheme, considered to demonstrate objective evidence capable, on the balance of probabilities, of confirming lower back pain symptoms and received the higher category of award. If there was abnormal radiology of the sacroiliac joints, the complaints were deemed to be medically verified.
194. Several applicants who complained of significant back pain were unable to provide any evidence either of complaint made to their GP or that the back pain was temporally associated with symphysiotomy. They were referred for radiological examination and assessment by the two orthopedic surgeons assisting the Scheme. I was advised that in the absence of abnormal findings at the pubic symphysis and sacroiliac joints, any late developing scoliosis, spondylolisthesis, disc protrusion, spondylitis,

general osteoarthritis, autoimmune disease, facet joint arthropathy or other back conditions could be dissociated from symphysiotomy.

195. It was found, as with the complaints of incontinence, that for the most part there was very little evidence of complaints of back pain made to the applicant's GP. Of importance, there was no evidence of any referral for the most basic and inexpensive first stop investigation for back pain – a plain x-ray. In such cases, no weight was attached to generic type specially obtained reports from non-treating doctors who confirmed current back pain.

196. 19 applicants established their complaints of back pain, 11 from medical records and 8 from radiology.

197. Many applicants complained of a **waddling gait** or of having **one leg shorter than the other**. Abnormal gait was not observed when these applicants were referred for orthopedic assessment. No case of leg shortening was established. 3 applicants had what was described by their GPs as a "wide gait". In 2 cases the diastasis was over 20mm.

#### **MISCELLANEOUS**

198. **4** applicants established significant disability under a number of uncategorised headings: 1 neurological thigh pain, 1 very extended period of recovery, 1 had a particularly difficult subsequent pregnancy and 1 applicant had exacerbation of a severe congenital hip dysplasia.

#### **CATEGORY 1C**

199. This category was confined to those cases where an elective/prophylactic symphysiotomy was carried out before labour commenced or where the pubic symphysis was divided after caesarean section while the patient was still under general anaesthesia. This combined operation was often

referred to as symphysiotomy *on the way out*. In both cases a narrow pelvis was identified and a decision taken to widen the pelvic outlet to facilitate childbirth and create a permanently widened pelvis. Both procedures were initially hailed as innovative and revolutionary but then came to be viewed as too interventionist and were abandoned by the obstetric community in Ireland before symphysiotomy was phased out. The Lourdes Hospital abandoned both procedures in 1970.

200. 38 cases of elective/prophylactic symphysiotomy carried out before labour commenced were identified and awards were made. The procedure was identified from birth registers, annual reports and from available hospital records. 9 of these cases involved a finding of significant disability and they each received the maximum award of €150,000. A wide diastasis was found in 3 of those cases including 1 applicant who had undergone plating of her pubic joint. In the case of 2 applicants, radiology identified severe pubic joint disruption. 1 applicant suffered sexual difficulties due to pubic pain. 2 applicants suffered chronic urinary tract infections and 1 applicant suffered non-symphysiotomy related obstetric issues which resulted in an extremely long recovery period.

201. 17 cases of combined operation '***on the way out***' were identified from birth registers, annual reports and from available hospital records in the case of the Lourdes Hospital<sup>87</sup>. 4 of these cases involved a finding of significant disability and they each received the maximum award of €150,000. A wide diastasis was found in 1 case, 3 applicants suffered psychosexual difficulties attributed to pubic/pelvic pain including 1 who had no further children.

#### **CATEGORY P1 AND P2 – PUBIOTOMY**

202. As mentioned previously, we found no evidence to support the contention that pubiotomy was performed at the Lourdes. The procedure was not

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<sup>87</sup> In 1 case, no records were available. The case depended on scar evidence.



referred to in any clinical file or any annual report. It was not identified in any radiology. I am reasonably satisfied that pubiotomy was not a procedure used at the Lourdes Hospital.

203. The last pubiotomy was performed in the Rotunda in 1951. Between 1944 and 1951, 10 pubiotomy procedures were carried out. The Rotunda preferred caesarean section to symphysiotomy to relieve moderate disproportion. It then adopted symphysiotomy in 1952 when the procedure was performed after caesarean section as a prophylactic procedure for future deliveries. It is appropriate to repeat the then Master's views on symphysiotomy in 1951:

*"I am sorry that I have been regarded by one speaker at the "bad boy" as I had not done any symphysiotomy during the year. I would do the operation when I consider it indicated on medical grounds, namely, when outlet contraction of sufficient degree is encountered unexpectedly. I do not consider prophylactic symphysiotomy justifiable, but possibly low mid-pelvic disproportion might be answered by this operation and an easier delivery completed in emergency with less risk of damage to the child. I wish it to be clearly understood that the operation of sterilisation is not performed in the Rotunda Hospital. In my opinion, the lower segment delivery, if compared with an equally large number of symphysiotomy deliveries, will yield a lower foetal maternal loss and damage rate. I accused myself of over conservatism in the use of Caesarean section in the earlier part of my Mastership. I regret that Dr. Spain picked up on the foetal loss in forceps deliveries in the Rotunda, and I believe the subject should be reviewed over a longer period. I am certain that delivery is indicated, conditions for forceps being fulfilled, when advance by natural forces has ceased."*

204. Symphysiotomy after caesarean section was performed 7 times in 1952 at the Rotunda. Dr. Hugo McVey who was a strong advocate of performing symphysiotomy on women with significant disproportion presented a paper to the Royal Academy of Medicine advancing the value of such procedures in 1953.

205. We found no record of pubiotomy procedures at the Coombe at all in any reports from 1944 onwards. Dr. Feeney admitted accidental cutting of bone while carrying out symphysiotomy, once in 1950 and once in 1951.
206. The last recording of pubiotomy at the NMH was in 1944. 3 further symphysiotomy procedures were performed by Dr. Spain where he described that he had cut the pubic bone because the pubic symphysis could not be identified. 2 of those were in 1951 and the third procedure was in 1952 and was described as an inadvertent pubiotomy.
207. On two occasions, there was radiological evidence of damage to the pubic bones but investigations confirmed that these applicants did not undergo pubiotomy and were not the patients referred to in the NMH or Coombe reports. Several applicants suffered from age related insufficiency fractures of a pubic ramus and several others suffered fractures of the pelvic bones but which did not constitute pubiotomy<sup>88</sup>. Radiology evidence of pubic bone fracture was presented as proof of pubiotomy in one very troubling application. The cases had first been made that the applicant had undergone symphysiotomy. The records of her many deliveries did not support the claimed symphysiotomy. Radiology of her symphysis pubis was normal and there was no symphysiotomy scar. Medical reports were furnished which supported the pubiotomy claim and the radiology showed evidence of a pubic bone fracture. The applicant had undergone a hip replacement in the last 15 years and her file at the orthopedic hospital contained a series of x-rays carried out at the time<sup>89</sup>. There was no evidence of any pubic bone fracture at that time. It was considered that she had sustained the fracture between the date of the hip replacement and the application and that she did not undergo either pubiotomy or

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<sup>88</sup> To effect pubiotomy the bones must be completely separated by sawing through. In each case, there was clear evidence of separation of the pubic symphysis. In two other cases where pubiotomy was claimed, earlier radiology indicated unequivocally that the pelvic fractures had occurred in the relatively recent past.

<sup>89</sup> Obtained by the Scheme's radiologist on the basis of written consent to investigations as part of the application process.

symphysiotomy. Puncture scars which had been attributed to pubiotomy were scars from a urogynaecology operation.

The only established pubiotomy among applicants was performed in Galway in 1962. Radiology showed two clean separations of the bone of either side of the pubic symphysis which I am informed was unusual. Another possible pubiotomy case came to light when we were carrying out a lookback audit of Annual Clinical reports. A comment was found to the effect that a pubiotomy was carried out inadvertently. The applicant had claimed for symphysiotomy and was assessed on this basis. Radiology confirmed that no pubiotomy had been performed. The applicant had a totally normal pelvis. We can only assume that the notation of inadvertent pubiotomy was made in error as the symphyseal separation was identified.

208. We had no way of determining whether pubiotomy was ever performed in any other hospitals apart from two of the Dublin maternity hospitals. Radiology advice was that identifying an old pubiotomy was a simple matter. If pubiotomy had been carried out the callus formation on the healed fracture line is permanently present on x-ray and is very obvious to see. Pubiotomy was excluded in every case made apart from the applicant who had the unusual bi-lateral procedure in Galway. Pubiotomy was not established in any case apart from one case from Galway. If it was performed in other hospitals, then the patients either have passed on or did not apply to the Scheme.

## INELIGIBLE CLAIMANTS

209. Almost **600** applications for participation in the Payment Scheme were received. This includes 27 applications received after the closing date that were therefore technically out of time.<sup>90</sup> 563 applications were received in time and given SPS numbers. 15 late applicants were later accepted and 12 late applications were not accepted. The total number of applications accepted was 578. The gross total received was 590.

210. All applications capable of being examined, including those received after the closing date<sup>91</sup>, underwent full investigation to establish whether a symphysiotomy could be established from the existing records and from medical examinations.

211. It was evident from an early stage of the working of the Scheme that many elderly women had been convinced –

- that they had undergone symphysiotomy,
- that the symphysiotomy was deliberately inflicted on them by obstetricians who had a religious agenda,
- they had suffered a series of life changing painful consequences

212. In view of possible external influences on these mostly elderly applicants, I decided to operate a low threshold for finding significant disability once a qualifying procedure was established. However, the procedure **HAD** to be **ESTABLISHED**. Many applicants should never have persuaded themselves to make a claim for payment for a procedure they did not have.

213. Of those who were received and given an SPS file number, 173 applicants were deemed by me to be ineligible for payment. The number includes 4

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<sup>90</sup> The final number of applications received was 590.

<sup>91</sup> See paragraphs dealing with late applications which included 12 applications where no qualifying procedure had been performed.

applications declared ineligible for other reasons being 2 applications that were brought on behalf of women who were deceased and 2 applicants who claimed for symphysiotomy performed after 1990<sup>92</sup>.

214. **12** of the late applicants were rejected on the basis that no qualifying procedure was established. This means that a total of 185 claims or that almost 1 out of every 3 applicants did not undergo symphysiotomy or pubiotomy.

#### **BREAKDOWN OF THE UNFOUNDED CLAIMS THAT WERE GIVEN SPS NUMBERS**

- **48** applications were under Category 1A for symphysiotomy procedure only.
- **92** applications were under Category 1B for symphysiotomy with accompanying significant disability.
- **3** applications were under Category 1C for a combined caesarean section with Symphysiotomy, **2** of those with significant disability.
- **2** applications were for a payment under Categories P1 or P2 for a pubiotomy procedure
- **28** submitted multiple applications for payment under various categories for symphysiotomy and/or pubiotomy, with or without accompanying significant disability.

215. It was an essential requirement of the Scheme that a qualifying procedure had to be established as a pre-requisite to assessment for payment of an award. Every application was therefore subjected to a thorough investigative process and full review before any final decision to exclude was made. Every applicant who expressed doubt about the reliability of the content of her records or who had no records was invited to undergo radiology and medical examination. The Scheme always paid for those

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<sup>92</sup> *It is assumed that these symphysiotomies were either spontaneous or breech deliveries involving a trapped after coming head in 1995.*

examinations although some applicants preferred to use their own specialists.

216. **65** applications were withdrawn by applicants or by their assisting solicitors when it was recognised that there was no evidence supporting the symphysiotomy claim. This figure of **65** is included in the 173 claims declared ineligible.

217. There were approximately 25 cases where there was no engagement with the Scheme beyond the furnishing of bare application forms without any supporting evidence. When the file number came up for assessment in its chronological or accelerated turn, there was nothing to assess. The applicants were written to and requested to either submit relevant documentation or undergo appropriate medical investigation. While most of those reluctant applicants did eventually respond and cooperated with the investigations at the Scheme's expense, some failed to respond in any way. A letter enclosing a stamped addressed envelope for return to me was sent inviting each such applicant to confirm if she intended to proceed with her application and if so, whether she would attend for medical examination. I wrote again reminding those who still did not respond that they left me with no alternative but to deem their application ineligible unless they cooperated within a certain time period. **8** applicants still made no response and made no contact and were ultimately declared ineligible on the basis as they had failed to cooperate in any way in establishing a qualifying procedure.

#### **LATE APPLICATIONS NOT ACCEPTED**

218. **27** application forms were received after the closing date of 5<sup>th</sup> December 2014 but within the discretionary period for acceptance if exceptional circumstances were provided<sup>93</sup>. My discretion was invoked to accept 15 of these late applications. In all the claims, a symphysiotomy had been

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<sup>93</sup> Up to 14<sup>th</sup> January 2015.

performed and I considered that the interests of justice would be observed to receive those applications into the Scheme notwithstanding applications sent in after the closing date.

219. **12** of the late applications were not accepted into the Scheme:

- In **6** cases, I was able to confirm from relevant hospital records/registers or medical examinations that the late applicant either did not undergo symphysiotomy (**4**) or had suffered spontaneous symphysiotomy (**2**).
- In the **6** remaining cases, the late applicant was asked to provide further information and/or documentation but failed to respond (**5**) or provided a reason that did not amount to exceptional circumstances from which I could exercise my discretion to admit the claim into the Scheme (**1**).

#### **HOW DID SO MANY GET IT WRONG?**

220. Almost a third of applicants did not undergo symphysiotomy. This is a very significant number. Even if applications made on behalf of those who simply *did not know* whether they underwent symphysiotomy or where family members thought their mother might have undergone such a procedure are excluded, the number (185 in total) still begs some examination and scrutiny. How could these *don't knows* and so many other women wrongly believe that they had undergone this procedure with its highly publicised adverse effects?

221. I exclude 23 of the ineligible applications which involved spontaneous symphysiotomy<sup>94</sup>, a naturally occurring subluxation of the symphysis pubis joint causing an abnormal separation of the pubic symphysis. This condition can occur during perfectly healthy pregnancies and deliveries and sometimes with extremely fit athletic young women. While the

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<sup>94</sup> More generally described as Pelvic Function Disorder. 2 of this number were late applicants who were not received into the Scheme.

condition is not particularly common, it is well recognised and is usually diagnosed within 12 hours of the delivery as the new mother complains of severe groin pain. The pain is centred over the pubic and sacroiliac joints and frequently the inside thigh muscles and she has extreme pain and difficulty getting out of bed. The condition is extremely painful. It can temporarily inhibit walking or climbing stairs and requires several modalities of treatment including binding, physiotherapy, rest and acupuncture. I am advised that the condition is usually self-limiting and eventually recovers. Spontaneous symphysiotomy is not a surgical procedure. It was notable that although the condition is recognised as very painful, the applicants did not furnish statements outlining the same degree of disability described in many surgical symphysiotomy claims. I have no criticism of these 23 ineligible applicants. They knew that their records contained the word *symphysiotomy* and that they had been treated for this condition. *Symphysiotomy* appeared on their records and they can be forgiven for not distinguishing between surgical symphysiotomy and spontaneous symphysiotomy.

222. It would be simple to explain away the remaining 162 unfounded claims as errors in memory associated with a bad experience of a first labour. This was certainly my first impression, but analysis of the statistics demonstrates that only 13 ineligible applicants fell into the category of possible *voluntary infertility*. In other words, only 13 ineligible applicants out of 185 had no further children following their first delivery. It is not known whether the infertility was due to miscarriage, separation from partner or other factors. All that is known is that 13 women stated in their application forms that they had no further live children after the birth at which they wrongly but perhaps understandably, believed that symphysiotomy or pubiotomy was performed. The other ineligible claimants had between 1 and 10 further babies.

223. Those 13 applicants whose first labour and delivery may have created a revulsion to further pregnancy which they blamed on symphysiotomy still



leaves the vast bulk of the women whose experience of first delivery was not so horrific and includes those applicants who had already obtained their medical records before applying to the Scheme and were therefore aware that the word symphysiotomy (or pubiotomy if it was claimed) did not appear anywhere on their records. The issue becomes a little murkier in those cases where it was asserted that the symphysiotomy was performed without their knowledge and was deliberately not recorded.

224. It is very possible that advertising by some legal firms to encourage women who “may” have undergone symphysiotomy to bring claims resulted in many of the unfounded applications<sup>95</sup>. The applications may have been submitted simply in order to comply with the application time period before the necessary supporting medical records were obtained. While there may have been a vexatious element to their applications, many of these applications were withdrawn once their records were examined. In others, misunderstanding between episiotomy and symphysiotomy was evident.

225. The publicity surrounding the activism for the Government to set up a compensation scheme for symphysiotomy *victims* was quite intense. There can hardly be a person in Ireland who has not been exposed to reports of the procedure described as *butchery akin to Nazi medical experimentation*;; *aggravated sexual assault*; *a form of female genital mutilation causing life long disability, chronic pain, mental suffering and family breakdown*<sup>96</sup> and much more. These reports have been so persistent and frequent that they have created something akin to a knee jerk reaction to the word symphysiotomy. It is viewed as a procedure synonymous with barbarism and pain; but not just *barbaric* and *painful* but *unnecessary* and *unwarranted*, creating a legacy of countless *victims* whose lives were *permanently ruined*. In this context, the large number of claims from women who did not in fact undergo symphysiotomy was

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<sup>95</sup> This would explain why a series of claims emanated from hospitals in counties not known for performing symphysiotomy.

<sup>96</sup> These are all quotations from published articles, opinions and interviews

completely unexpected. It is also now known that some of those ineligible applicants that is, women who did not undergo symphysiotomy have been prominent, vocal and long time activists as *victims of symphysiotomy*.

226. After much thought, I concluded that it is very probable that the combination of a traumatic birth experience and exposure to other women's stories has created a self convincing confabulation of personal history. Another inference is that the possibility of financial payment has influenced suggestible women and their family members into self- serving adoption and embracing of the experiences described by others or in the media and created psychosomatic conditions.

227. While most mistaken applicants were elderly and possibly amenable to suggestion and to emotional contagion, there were certainly some amongst the ineligible applications who were considerably younger and who appeared angry or disappointed when informed that evidence to confirm symphysiotomy was completely absent. A reasonable person could be forgiven for thinking that as symphysiotomy is projected as a barbaric procedure creating lifelong disability, any mistaken applicant would welcome the information and accept it as akin to a reprieve from an erroneous terminal diagnosis. However, it is for experts in the field of psychology to analyse the effects of group discussion on suggestive personalities.

228. Many applicants - both those who received an award and those who did not undergo symphysiotomy or pubiotomy - who provided personal statements complained that they were unaware, even though they suffered many painful symptoms, that a symphysiotomy had been performed and they especially complained that they were totally ignorant of what to expect when discharged from hospital. If a symphysiotomy had been performed, these assertions predicate resolute and conspiratorial silence on the part of nurses who removed catheters, who provided painkillers and who removed bindings and sutures from the

symphysiotomy incision; from physiotherapists who encouraged patients to mobilise; and from the obstetrician who conducted the 6-week check up. It ignored the letters written by the consultant to their GP informing of the birth and any relevant procedures involved (which was and is current practice).

229. The fact that so many applicants stated that they were unaware that they had undergone symphysiotomy until they heard/saw/read something in the media is readily explained when they did not ever undergo symphysiotomy. Lapse of memory in others who did undergo symphysiotomy is less easy to understand.

230. In view of the established evidence of the recording of each symphysiotomy on patient records, it is very difficult to believe that any patient who had actually undergone symphysiotomy was not told of the procedure or the possibility that a procedure was contemplated if she had undergone pelvimetry. A symphysiotomy procedure<sup>97</sup> involved positioning the patient between two nursing or medical attendants - not in gynaecology stirrups as described by so many applicants - to ensure careful and measured abduction or separation of the legs at the division of the pubic symphysis. It involved full anaesthesia in the very early years and from at least the 1950s, local anaesthesia where the pubic area was numbed by infiltration of lignocaine by a series of injections. There is always a time lapse between the injections and their numbing effect before the incision and then separation of the fibres of the pubic symphysis. The procedure was carried out by consultants<sup>98</sup>, who in that era were mostly male in contrast to the female midwives. While criticism might be due regarding the patient's comprehension of the information given, I am reasonably satisfied that patients were informed that symphysiotomy had been carried out and why. In the case of elective symphysiotomy carried out in advance of labour, the case for provision of that information is even stronger.

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<sup>97</sup> See the Chapter on technique on how to carry out a symphysiotomy procedures

<sup>98</sup> The operation was sometimes carried out by registrars but with a consultant observing and guiding

231. My view is reinforced by the not infrequent references to a *previous symphysiotomy* in specialist reports and records of those few patients who within 10 years of the procedure complained of back/hip/incontinence issues and whose conditions were investigated. Informed consent is a quite different issue, as the legal principles involved were not formulated until the cases of *Walsh v. Family Planning Services* [1992] 1 IR 496 and *Geoghegan v. Harris* [2000] 3 IR 536.

232. Perhaps, the most disturbing feature of unfounded applications<sup>99</sup> is that some of the applications were supported by the medical personnel they had attended. Reports were submitted from those experts, which confirmed the symphysiotomy and on some occasions, pubiotomy. It seems that a written statement was given to the expert who accepted the truth of the contents and as the qualifying procedure was accepted, significant disability was automatically found as a consequence and the effects were stated to have lasted in excess of 3 years and continue to date.

233. Slightly less disturbing was the number within those ineligible applicants who claimed significant disability caused by symphysiotomy that they did not have. Many of those applicants provided statements outlining details of what they heard, saw and endured at the time the perceived symphysiotomy was performed and what they had suffered since. It is noted that 28<sup>100</sup> applicants who had not undergone surgical symphysiotomy have initiated legal proceedings in the High Court in respect of the alleged symphysiotomy procedure which they did not have.

234. Many personal statements closely mirrored the wording in statements received from applicants who underwent confirmed symphysiotomy. While some statements were handwritten and others typed, there was an

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<sup>99</sup> I completely exclude those 23 applicants who had a natural subluxation/spontaneous symphysiotomy from these comments

<sup>100</sup> This number is possibly 37 as some applicants did not furnish the information.

extraordinary similarity in their format. There was a strong suspicion that symptoms described reflected the injuries complained of by the successful plaintiff in the High and Supreme Court judgments of *Kearney v McQuillan* [2012] IEHC 127 and [2012] IESC 43.

235. The following phrases appeared regularly in the statements of women who did **not undergo symphysiotomy**:

- I will never forget the sound of the saw cutting into me...
- I was told that as a Catholic I would be expected to have 10 children whereas if I had a caesarean section I would have to limit myself to 3 children<sup>101</sup>
- The consultant told me I had to do a little job on you<sup>102</sup> “
- a nurse told me that they had to cut/break my pelvis
- my pelvic cage was not opening and I would need surgery after which I would give birth in the future without the same complication.
- I never bonded with my baby
- I had to learn to walk again
- I could not even stand never mind walk
- I could not look after my baby
- I had to crawl on all fours to go to the toilet
- unknown to me a medical procedure was performed on me without consent or knowledge
- I was told a bone had to be removed that was obstructing the birth.
- unseen damages were suffered [by me] as a direct result of having had this unnecessary, unsolicited and unauthorised procedure carried out whilst being anaesthetised<sup>103</sup>
- this horrific experience

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<sup>101</sup> Several applicants named an obstetrician known to be a devout Catholic but no symphysiotomy procedure was ever associated with him

<sup>102</sup> Dr Neary was not working in the hospital at the time

<sup>103</sup> Her baby was delivered by caesarean section

- the negative impact of having been abused and assaulted while in a state of unconsciousness changed my whole course of life...'
- I had a horrific night of discomfort and pain
- I tried to get out of bed but my legs were like jelly
- My husband had to carry me out of the hospital
- When the nurses wanted me to get out of the bed I collapsed on the floor
- I had to use a chair to help me walk when I got home
- I had to lie on my side to feed the baby
- I was unsteady and fell all the time
- I was told to wear a roll on corset/back brace night and day
- I could not do normal chores - no Hoovering or housework
- I could not climb stairs
- I had to come down the stairs on my bottom
- I had no support; I felt that my insides were falling out
- I could not push my baby's buggy
- I could not leave the house as I was incontinent
- For months, to relieve pain and discomfort, I would only lie flat out on the broad of my back
- Even pressing my finger on my tummy still hurts after all this time
- I am still tender in pubic / pelvic area
- I have one leg shorter than the other
- I walk with a waddle
- The symphysiotomy 'damaged me for the rest of my life
- I have flashbacks and panic attacks
- I have a phobia of hospitals

236. Memories recounted of the aftermath of the delivery and resultant lifelong difficulties asserted also bore remarkable similarity to one another and, as previously mentioned, with the statements of applicants with established symphysiotomy. Incontinence, sexual difficulties, depression, back pain and mobility problems were the most frequent disabilities attributed to the

procedure, which had not been performed. A significant number of applications involved assertions of loss of consciousness with loss of memory of events for many hours. It was invariably asserted that when they awoke, the baby had been born and they were in excruciating pain.

## CONCLUSION

237. The examination of all claims that were ultimately declared ineligible was rigorous. Whenever an applicant had difficulty in establishing her claim, for instance if her medical records were difficult to locate, she was assisted by members of the team and the Scheme's resources were applied towards that investigation. I am confident that every decision to exclude an applicant from receiving an ex gratia award was appropriately made. This contrasts with the situation where, as outlined in previous chapters, I believe that early uncritical reliance on medical reports led me to make awards where it is highly probable that no symphysiotomy was performed. The numbers of ineligible applicants outlined above could in fact therefore be higher.

238. **185**<sup>104</sup> of all applicants did not qualify as eligible for payment as they had undergone neither a pubiotomy nor a surgical symphysiotomy. That figure is larger than the **173** ineligible applications received into the Scheme as it includes **12** further applications that were presented late. That fact notwithstanding, full investigations had been conducted to determine whether, in the interests of justice, the time limit would be extended. Those 12 cases that were not received into the Scheme because either no symphysiotomy or pubiotomy was established (**6**) or where no cooperation was received (**6**).

239. I must confess to a feeling of great sadness for those applicants who somehow believed that they were victims who had survived symphysiotomy only to learn that they were mistaken and that their

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<sup>104</sup> 173 accepted applications given an SPS number and 12 late applications which were not accepted into the Scheme

recollections were based on error. Elderly women should not have to face such emotional turmoil. I have no doubt that some of them have spent good money presenting their claims which cannot be recouped. Those who have been active in representing themselves as victims to the media must now retrace their lives and must be understandably upset.



## LOOKBACK

### LOOKBACK ON SYMPHYSIOTOMY AND ASSOCIATED MORBIDITY

240. As mentioned in the Overview at Chapter 1, this Payment Scheme was premised on certain basis - the most important of which was that women who had undergone a symphysiotomy delivery suffered serious and continuing life changing disability. Included in those disabilities were severe mobility problems and incontinence. The assessment of almost 600 applications did not support these preconceptions. No claim of mobility issues associated with symphysiotomy was established although there is no doubt that many of the applicants who are in their late 80s do suffer from a degree of unsteadiness and many suffer from vertigo. The objective findings made were the 12<sup>105</sup> women who had radiological evidence of grossly abnormal pubic symphysis and the 63 women who had a continuing wide diastasis.
241. It was fully expected that applicants would with ease establish the case of inability to walk even three years after the symphysiotomy. That case was not made out by any applicant and in fairness such claim made by very few. Similarly, it was expected that incontinence would be easy to establish. In fact only 5 urinary injuries associated with the symphysiotomy birth were established although one was connected with a traumatic shoulder dystocia and at least one case of fistula with prolonged obstructed labour before symphysiotomy was performed.
242. Had it not been for recent radiology and had the applicants not had their imaging read by our advising radiologist, very few cases of significant disability would have been established. The condition of the pelvic joint was the reason for a finding significant disability in 24 cases, 6 of those concurrently with wide diastasis. In some of these 24 cases, pubic joint

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<sup>105</sup> Some of the 12 applicants also had a wide diastasis

pain in the past was assumed due to radiological evidence of past inflammation but 12 of that group received awards for assumed past or continuing pubic pain due to joint disruption. There 7 cases where an iatrogenic component was suspected as for instance, when the scalpel damaged the adjoining bone. 4 of these cases demonstrated evidence of joint movement in the past and one woman showing instability in the joint at the present<sup>106</sup>.

243. The extraordinary factor was that in almost all of the cases of *joint abnormality*, the condition of the joint had never been investigated and only came to the fore when Professor Lawler reported on x-ray imaging. Other radiologists had either not seen or had ignored the condition of the joint unless they mentioned the separation or the presence of gross sclerosis. Radiology findings made by the Scheme's expert were instrumental in my assumption of pelvic pain/pubic pain/dyspareunia in all these cases of joint abnormality. Significant disability was also assumed in 63 other cases where a continuing diastasis of 15mm or more was found. It is not known whether continuing diastasis without co-morbidities contributes to pain or discomfort as so many of this group of women led active lives and very few women had consulted orthopedic services until they were elderly.

244. As the evidence to support most other claims was difficult to find or was even completely lacking, I found myself lowering the criteria for what constituted significant disability in order to help applicants *over the line*. This is not what was expected. It was seriously perplexing that complaints made by or on behalf of so many applicants were simply not matched by the medical evidence. I wondered if there was any possibility that our experience was non-representative of the actual facts because the patients with serious morbidities caused by symphysiotomy had either died or had chosen not come to the Scheme for redress.

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<sup>106</sup> Many of the features seen in abnormal joints are also found in elderly women who have not undergone symphysiotomy

245. After reflection, I decided that it would be remiss to waste the opportunity to conduct further research into this issue. A great deal of literature had been obtained and was in our hands including most of the Annual Clinical Reports. In order to determine the extent of the morbidities attributable to symphysiotomy, we determined to examine the full content of Clinical Reports from 1944 onwards and to view the historical context and state of knowledge in which these procedures were performed. We also obtained the full set of written records of Transaction Meetings for the period when symphysiotomy was an obstetric procedure iperformed in leading maternity hospitals in Ireland. It was hoped that some accurate estimate of the degree of symphysiotomy related morbidities/adverse events during the relevant time could be established. At the same time, we would take the opportunity to review maternal deaths and fetal losses in the 3 Dublin Hospitals and at the Lourdes Hospital as context of the events of so long ago.

246. We had noted that the highly respected medical textbook Munroe Kerr and Chasser Moir on **Operative Obstetrics** edited by **Baskett, Calder and Arulkumaram**, Saunders Elsevier, 2014 states in the chapter on symphysiotomy *“overall, in large series of symphysiotomy conducted by appropriately trained personnel, the incidence of longterm orthopedic and urinary complications is around 2%”*. If that was the case, why were so many Irish women claiming a 100% rate of such complications and why were they supported by some doctors in that view?

247. It took some time to be able to obtain the more ancient Clinical Reports and the records of Transaction meetings<sup>107</sup>. I am very grateful to the librarians at Trinity College and RCSI Heritage Centre and UCD who retrieved these very old reports from their stored archives and made the booklets available to us to photocopy. We would have been unable to conduct our research without their very kind assistance. I also thank the liaison officers in the Rotunda, the NMH and the Coombe for their

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<sup>107</sup> going back to 1944

assistance and forbearance in providing copies of original reports and for allowing us to make photocopies. They collectively enabled us to conduct this further research.

248. 361 applicants named the 3 Dublin hospitals and the Lourdes Hospital in Drogheda as the place where symphysiotomy was performed. Only 270 of those claimants actually underwent the procedure. I have already dealt at length with the 1 in 3 applicants who were incorrect in their belief that they had undergone a symphysiotomy procedure in the chapter on applicants who were ineligible for payment.

249. The following claims were established in the hospitals relevant to this research:

- 68 claims involving the NMH,
- 46 involving the Coombe,
- 13 involving the Rotunda, and
- 143 involving the Lourdes.

250. As previously explained, the only hospitals to publish clinical reports were the Rotunda, Coombe, NMH and the Lourdes. Sometimes we were provided with a glimpse into the workings of other hospitals because we have a record of their comments at the Transaction Meetings held annually to specifically discuss the contents of the reports from the Masters of the Dublin maternity hospitals. We know therefore what Prof. W Kearney said at 2 Transaction meetings in 1953 and in 1957. In 1953 he said *"In Cork we were initially very much against symphysiotomy. Now we do it in the odd case. There is much to be said in its favour. Psychological trauma from loss of the first baby is a problem."*

251. In 1957 he criticised the Rotunda report by saying: *"Symphysiotomy was not considered under a separate heading in the Rotunda Report and I could find only two references to it. On page 50 it is stated that symphysiotomy was carried out at the time of performing section in one*

case. On page 56 we read that "the operation continues to be used to a very small extent in the hospital, and only for very selected cases of android pelvis in young patients". In contrast the operation was performed on 32 occasions at the Coombe and on 21 cases at Holles Street. At the Erinville Hospital, Cork, we subscribe more to the view expressed by the Master of the Rotunda and confine the operation to relatively young women with mid-cavity and outlet reduction. Nevertheless in 1956 we performed it 4 times in 1,150 intern cases. Surely there must have been several cases during the year that qualified for this operation at the Rotunda. If so, they are not mentioned in the Report. If the operation was not performed except in the one case already quoted, then the Master's limited approval of it is more theoretical than real. I believe that there is a definite place for symphysiotomy in a predominantly Catholic country such as Ireland, where contraception and sterilisation are not countenanced by over 90 per cent of the population. In such circumstances the performance of Caesarean section on a young woman for contracted pelvis is a serious step and should not be lightly undertaken. It means that she may be faced with many repeat sections with increasing risks each time. Symphysiotomy lowers the incidence of section in cases of disproportion. When performed on carefully selected cases it is a safe operation and gives gratifying results. As it is a simple procedure, the technique of which can be readily mastered, there is a real risk of it being performed too often and unnecessarily. It is not an operation for the general practitioner doing domiciliary deliveries. It should be given the same careful consideration as Caesarean section and requires the expert judgement of an experienced obstetrician. I think it was Munro Kerr who said "let me see a man deliver a breech and I will assess his obstetrical ability". To a lesser extent the efficiency of a maternity unit may be judged by its attitude towards breech delivery. The results reported under this section are good in all 3 Hospitals. It would appear that the Rotunda permits a limited number of breeches to be delivered on its District, 31 in 1,013 cases as against 8 in 1,161 for Holles Street and the Coombe together".

252. There are records of comments<sup>108</sup> made by Dr Connolly at the Lourdes Hospital but it is not necessary to record them here as we had a complete set of published reports from that hospital. We had no Clinical Reports from any of the Cork hospitals where symphysiotomy was performed nor from the Galway General Maternity Unit.
253. Once the full set of Clinical Reports from 1944 was obtained, we sought to correlate the complaints of incontinence and mobility issues with specific and general entries in the Clinical Reports. I particularly sought to determine whether the adverse events/findings/morbidities recorded would support the opinions expressed by some specialists<sup>109</sup> that incontinence, mobility problems, pelvic instability and back pain were the normal consequence of surgical symphysiotomy.
254. The Annual Clinical Reports were a rich and deep source of extremely valuable contemporary documentary evidence. The level of detail in those reports indicates the non-litigious culture at the time as mistakes were readily admitted and bad outcomes described frankly. They are collectively an extraordinary archive of social history for medico-historians<sup>110</sup>.
255. A careful and time consuming audit was conducted of the Annual Clinical Reports of the Hospitals who produced them to establish the context of conditions for mothers and babies at the era relevant symphysiotomy.

**RELEVANT STATISTICS FOUND IN ANNUAL CLINICAL REPORTS<sup>111</sup> FROM 1944 TO 1970  
DIVIDED INTO GENERAL; SYMPHYSIOTOMY AND CAESAREAN SECTION:**

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<sup>108</sup> see Appendix III

<sup>109</sup> No expert who expressed such opinion had ever performed, assisted or observed a symphysiotomy.

<sup>110</sup> Appendix 11 and 111 contain the full documents

<sup>111</sup> **PLEASE NOTE:** While huge effort was made in compiling these charts to ensure accuracy with figures, due to individual hospital differences across definitions, reporting, styles, descriptions or calendar years in the hospital annual clinical reports (or indeed simple human error), accuracy cannot be guaranteed. The audit was significantly complicated by the lack of standardization in the content and format of the annual clinical reports. Discussions in Transaction meetings frequently criticized lack of standardization. Accuracy in and comparisons across the Tables may suffer slightly as a result.

Statistics for each obstetric activity were generally synopsized above each relevant Table in an annual report. Where the synopsis and individual details in a table did not wholly match or where full figures were ascertainable across multiple tables, the best figures were ascertained.

256. These Charts show the number of Deliveries in the hospital in general with the figures for overall maternal and foetal losses followed by similar figures for symphysiotomy, caesarean section and caesarean hysterectomy.

**LEGEND:**

In respect of hospital numbers: in general (**GEN**); Surgical Symphysiotomy (**SYMPH'Y**), Pubiotomy (+ **PUB'Y** - in brackets) and Caesarean Section (**C/SECT**), columns are headed:

**YR:** Year

**DEL:** Deliveries

**MAT MORT:** Maternal Mortality

**FTL L** Foetal Loss, which is then broken down in brackets into stillbirths (SB) and neonatal deaths (NND)

Final column records **C/HYSTY:** Caesarean Hysterectomy

**NATIONAL MATERNITY HOSPITAL:**

YR	GEN: DEL	GEN: MAT MORT	GEN: FTL LOSS	SYMPH'Y (+ PUB'Y)	SYMPH'Y: MAT MORT	SYMPH'Y: FTL LOSS (SB + NND)	C/ SECT	C/SECT: MAT MORT	C/SECT: FTL LOSS (SB + NND)	C/ HYSTY
1944	3187	17	221	2 (+2)	0	0	93	1	8 (0+8)	4
1945	3371	11	292	2	0	2 (0+2)	82	0	10 (2+8)	1
1946	3668	5	291	11	0	1 (1+0)	98	1	21 (3+18)	1
1947	3710	9	227	9	0	0	103	1	6 (4+2)	0
1948	3347	16	173	12	0	0	98	2	10 (3+7)	1
1949	3886	11	215	15	0	1 (0+1)	39	0	1 (0+1)	1
1950	4147	11	279	20	0	5 (3+2)	58	1	9 (3+6)	4
1951	4162	15	222	18	0	2 (2+0)	44	3	5 (2+3)	0
1952	4638	8	277	28	0	6 (5+1)	59	3	9 (4+5)	6
1953	4803	6	279	18	0	2 (2+0)	58	0	7 (4+3)	2
1954	4673	8	270	33	0	4 (1+3)	53	0	9 (3+6)	2
1955	4885	2	242	33	0	0	51	0	3 (0+3)	2
1956	4667	10	264	21	0	2 (1+1)	93	1	8 (2+6)	1

1957	4429	6	261	9	0	0	87	0	13 (2+11)	0
1958	4474	9	217	6	0	0	88	0	5 (1+4)	0
1959	4737	7	212	25	0	3 (0+3)	122	0	6 (1+5)	2
1960	5216	4	266	16	0	0	115	0	9 (1+8)	0
1961	5275	6	282	12	0	1 (0+1)	140	2	15 (6+9)	0
1962	5552	11	245	19	0	1 (0+1)	133	1	9 (2+7)	1
1963	5831	5	200	12	0	0	168	0	6 (1+5)	2
1964	5747	6	216	5	0	1 (0+1)	211	1	18 (9+9)	1
1965	5689	3	185	2	1	0	209	0	14 (4+10)	0
1966	5055	2	194	1	0	0	249	0	17 (4+13)	0
1967	5598	1	176	3	0	0	205	0	12 (3+9)	0
1968	5402	4	174	4	0	1 (0+1)	180	1	19 (6+13)	6
1969	6001	4	182	2	0	0	240	1	17 (1+16)	0
1970	6818	0	180	0	0	0	256	0	15 (4+11)	16
TTL	128968	197	6242	340 (338+2)	1	32 (15+17)	3332	19	281 (75+206)	53

## COOMBE

YR	GEN: DEL	GEN: MAT MORT	GEN: FTL LOSS	SYMPH'Y (+ PUB'Y)	SYMPH'Y: MAT MORT	SYMPH'Y: FTL LOSS (SB + NND)	C/ SECT	c/SECT: MAT MORT	c/SECT: FTL LOSS (SB + NND)	C/ HYSTY
1944	1766	8	126	0	0	0	36	1	4 (0+4)	0
1945	1777	8	94	0	0	0	57	2	6 (0+6)	1
1946	1811	5	63	0	0	0	63	2	11 (3+8)	3
1947	1804	3	91	0	0	0	59	1	1 (0+1)	0
1948	1704	5	72	2	0	1 (0+1)	62	2	2(0+2)	1
1949	1656	7	97	1	0	0	52	0	4 (2+2)	1
1950	2002	6	158	11	0	1 (1+0)	54	0	5 (2+3)	6
1951	2113	4	170	16	0	1 (1+0)	82	0	15 (1+14)	7
1952	2250	7	163	19	0	4 (0+4)	88	1	9 (3+6)	7
1953	2254	4	143	25	0	1 (0+1)	103	1	6 (1+5)	9
1954	2400	4	154	19	0	2 (1+1)	116	0	12 (5+7)	4
1955	2555	8	161	15	0	2 (0+2)	94	2	7 (1+6)	5



1956	2400	2	164	32	0	3 (1+2)	89	1	9 (5+4)	2
1957	2505	4	135	6	0	0	104	0	11 (5+6)	2
1958	2401	3	119	8	0	0	134	0	11 (5+6)	1
1959	2660	2	154	13	0	0	124	1	13 (4+9)	1
1960	2920	5	149	17	0	1 (0+1)	131	0	17 (4+13)	1
1961	3032	7	125	12	0	0	96	1	4 (2+2)	1
1962	3220	3	153	4	0	0	131	1	8 (0+8)	4
1963	3134	2	127	5	0	1 (1+0)	140	1	7 (1+6)	5
1964	3215	4	162	0	0	0	170	1	18 (4+14)	0
1965	3234	3	155	4	0	0	174	1	14 (6 + 8)	2
1966	3327	5	152	4	0	0	196	0	22 (5+17)	2
1967	3837	1	152	2	0	0	256	0	19 (3+16)	1
1968	5596	4	184	0	0	0	290	0	12 (2+10)	6
1969	5507	3	150	0	0	0*	346	0	11 (0+11)	7
1970	5681	3	151	0	0	0	376	0	18 (6+12)	8
TTL	76761	120	3724	215	0	17 (5+12)	3623	19	276 (70+206)	87

\* One Applicant to the Scheme furnished records confirming a Symphysiotomy in 1969 . The Coombe ACR stopped recording symphysiotomy after 1967

## ROTUNDA\*

YR	GEN: DEL	GEN: MAT MORT	GEN: FTL LOSS	SYMPH'Y (+ PUB'Y)	SYMPH'Y: MAT MORT	SYMPH'Y: FTL LOSS (SB + NND)	C/ SECT	c/SECT: MAT MORT	c/SECT: FTL LOSS (SB + NND)	C/ HYSTY
1944	3975	9	284	(4)	0	0	122	0	16 (6+10)	3
1945	4033	10	260	(4)	0	(1*)(0+1)	146	2	23 (4+19)	4
1946	3724	10	119	(2)	0	0	157	1	18 (6+12)	3
1947	3910	4	207	(2)	0	0	180	2	10 (6 +4)	5
1948	3918	14	247	(2)	0	0	95	4	6 (4+2)	4
1949	3928	9	244*	0	0	0	113	1	5 (5+0)	6
1950	3954	7	244	0	0	0	131	2	12 (6+6)	1
1951	4128	7	282	1	0	0	135	3	25 (8+17)	5
1952	4276	5	234	7 (+1)	0	0	204	1	34	3

									(18+16)	
1953	3993	8	223	3	0	0	154	1	15 (5+10)	3
1954	4367	5	223	2	0	0	160	2	16 (7+9)	6
1955	4177	2	191	2	0	0	167	0	10 (7+3)	1
1956	4456	5	193	1	0	0	148	0	10 (2+8)	0
1957	4474	7	245	1	0	0	211	2	25 (4+21)	0
1958	4366	8	215	1	0	0	171	0	7 (0+7)	1
1959	5183	5	244	0	0	0	189	2	6 (1+5)	3
1960	4694	6	262	0	0	0	196	0	15 (3+12)	1
1961	4690	5	256	1	0	0	224	2	18 (2+16)	1
1962	5012	5	256	3	0	0	243	0	26 (2+24)	3
1963	5199	6	209	3	0	0	270	2	15 (1+14)	4
1964	5769	6	268	4	0	0	335	2	30 (8+22)	5
1965	5772	4	219	5	0	1 (0+1)	376	0	21 (6+15)	3
1966	5767	3	195	8	0	1 (0+1)	330	1	14 (3+11)	0
1967	5795	6	207	0	0	0	326	2	18 (5+13)	2
1968	5842	2	178	1	0	0	301	0	15 (5+10)	2
1969	5849	1	159	0	0	0	349	0	9 (2+7)	1
1970	5936	4	169	0	0	0	348	1	16 (6+10)	0
TTL	127187	173	6033	58 (43+15)	0	3 (0+3)	5781	35	435 (132+303)	70

\* Rotunda ACRs were reported each year from 1/11 to 31/10 (not a calendar year) until 1960 – the YR cited in the Table is the year ending that October.

When the Rotunda changed practice from pubiotomy to symphysiotomy in the 1950s, all symphysiotomies were following caesarean section. Maternal / Fetal loss in symphysiotomy column up to 1951 refers to pubiotomy (ie 1945). 1949 general fetal loss is best estimate.

## LOURDES HOSPITAL\*

YR	GEN: DEL	GEN: MAT MORT	GEN: FTL LOSS	SYMPH'Y (+ PUB'Y)	SYMPH'Y: MAT MORT	SYMPH'Y: FTL LOSS (SB + NND)	C/ SECT	C/SECT: MAT MORT	C/SECT: FTL LOSS (SB + NND)	C/ HYSTY
1952	1301	1	58	6	0	1 (0+1)	21	0	1 (0+1)	2
1953	1303	4	58	14	0	1 (1+0)	28	1	0	0
1954	1388	2	74	30	0	3 (1+2)	32	1	5 (1+4)	1
1955	1409	2	64	27	0	1 (1+0)	24	0	1 (0+1)	0

1956	1417	2	61	28	0	1 (1+0)	16	0	1 (0+1)	0
1957	1339	1	61	17	0	1 (0+1)	35	0	1 (0+1)	0
1958	1460	1	66	21	0	0	44	0	2 (1+1)	1
1959	1572	1	77	17	0	0	44	0	7 (0+7)	3
1960 &61	3203	1	137	48	0	5 (2+3)	89	0	6 (1+5)	1
1962 &63	3455	2	113	40	0	0	87	0	5 (2+3)	2
1964 &65	4387	7	147	22	0	2 (1+1)	127	0	5 (2+3)	1
1966 &67	5007	2	160	31	0	0	152	1	11 (3+8)	9
1968 &69	5433	1	140	19	0	2 (1+1)	183	0	15 (4+11)	1
1970 &71	5756	3	146	26	0	1 (0+1)	199	1	24 (4+20)	2
TTL	38430	30	1362	346	0	18 (8+10)	1081	4	84 (18+66)	23

\* ACRs for The Lourdes are only available from 1952 and are biennial from 1960

#### **AUDIT OF SYMPHYSIOTOMY IN ANNUAL CLINICAL REPORTS:**

257. The reports make it clear that when symphysiotomy was re-introduced in the NMH in 1943 and in the Coombe in 1948, the Rotunda in 1951/1952 and the Cork hospitals from at least 1952 and the Lourdes in Drogheda in 1952, the possible morbidities associated with symphysiotomy of urinary incontinence, urinary tract injury or infection or difficulty in walking were known. These adverse incidents or morbidities were assiduously recorded in the Dublin reports and were, if serious, followed up in discussions at the Transactions Meetings.

258. The symphysiotomy charts contained in the annual reports were examined to see the extent of incontinence and other symphysiotomy related morbidities which were noted. The documents examined provided

descriptions of the techniques for symphysiotomy<sup>112</sup>. The descriptions invariably warned that care must be taken not to damage the urethra (a short narrow tube which carries urine from the bladder to outside the body) which lies just behind the symphysis pubis. The operator was advised to carefully insert a catheter into the urethra and then move the catheterised urethra away from the symphysis before the ligaments and fibres were divided with a scalpel or blade. The operator was warned that care must always be taken in the control and abduction of the patient's legs to avoid stretching the urethra or the sacroiliac joints<sup>113</sup>.

259. The reports showed that by the 1940s, lower segment caesarean section had replaced the higher segment *classical incision*<sup>114</sup>. While this change in technique greatly decreased the risk of uterine rupture and caesarean hysterectomy, the fact of resort to caesarean section at all was clearly viewed by most senior obstetricians as a failure in the art of midwifery<sup>115</sup>. It was evident that the 3 hospitals of the Dublin School were, at that time, somewhat fixated on keeping their individual caesarean section rates to a minimum. The rate was between 1% and 3% at the time. Contemporaneous recording of the Transaction Meetings which followed publication of the Dublin reports indicates keen, competitive and critical interest in each other's abdominal delivery numbers and results. Caesarean section delivery was not a procedure which was taken lightly as it carried significant mortality rates for the baby and not insignificant morbidities for the mother. Discussion on the pros and cons of caesarean section was always lively. Symphysiotomy then became another subject of division, discussion and dispute and especially with visiting UK obstetricians<sup>116</sup>. Disproportion was frequently discussed and was evidently an issue of concern in all obstetric units in Ireland and the UK at the time.

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<sup>112</sup> Chasser Moir, Spain, Barry, Feeney, Cunningham, MM Nolan, P McVey, Greig and others.

<sup>113</sup> There was never any reference to a saw

<sup>114</sup> There were exceptional cases when the classical incision was used as for instance in viable premature births and where the uterus was scarred in the lower segment

<sup>115</sup> The rate of caesarean hysterectomy was high by today's standards considering the low number of caesarean section.

<sup>116</sup> Not all visiting obstetricians were critical of symphysiotomy. See the chapter on history

## THE NMH

260. We started with the NMH reports as the symphysiotomy procedure was first carried out there. We noted that, caesarean section and symphysiotomy were described in separate chapters in the Annual Reports with tables showing each caesarean section and each symphysiotomy<sup>117</sup>. The patient's age and previous obstetric history and the reason for the caesarean section delivery or the symphysiotomy were noted. Maternal deaths, stillbirths and neonatal deaths (NND) were enumerated at the top of each table. The anonymised tables also provided the patient's hospital identifying number and in the case of symphysiotomy, the patient's pelvic measurements. Both charts provided the patient's age and previous parity, the baby's weight and condition and a short history of each outcome. The mother's condition on discharge was always described. If an adverse event was noted, that condition was referred to in the 6/8 week check up and frequently at her next delivery. There was a keen interest in reporting whether the next delivery was vaginal or by section.
261. Urethral tears, stretching of the urethra, bladder nicks or cuts and vesico-vaginal fistulae are potentially serious conditions where surgical intervention to mend the damage is frequently required. While these injuries are mainly associated with instrumental deliveries and prolonged labour, they are also injuries associated with symphysiotomy. We therefore sought out and noted each such injury recorded on the clinical reports. In particular we looked for every mention of incontinence or walking difficulties. We also had the benefit of several look back studies contained within those reports.
262. Dr. Alex Spain and Dr. Arthur Barry in the NMH and Dr. JK Feeney in the Coombe, the first obstetricians to carry out symphysiotomy in the State all maintained statistics of the success or failure of the symphysiotomy

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<sup>117</sup> The Rotunda did not follow this format. One had frequently to read the general narrative

operations they performed. They included several studies of their work in the Annual Clinical reports and provided details of the technique they applied to symphysiotomy. These confirm that until at least 1955<sup>118</sup>, symphysiotomy was performed using the open procedure rather than the sub-cutaneous method described by Frank, a German obstetrician in the early part of the century.

263. 338 symphysiotomies were performed at the **NMH** between 1944 and 1969<sup>119</sup>. This figure includes 3 symphysiotomy procedures that were converted into pubiotomy because of difficulty in identifying the symphyseal joint and 1 which was described as inadvertent<sup>120</sup>. The audit showed that the notes on each symphysiotomy performed while Spain and Barry were in office were very full and disarmingly frank. Dr. Spain's enthusiasm for the procedure was matched by his clinical honesty regarding his failures. An example of the reporting of a procedure is found in the 1946 Clinical Report:

CASE HISTORY:

*"At term, onset of labour spontaneous, head free. First stage, 17 hours, head engaging but still very high. Symphysiotomy performed, head now descended to level of spines. Forceps applied and baby delivered. Separation of pubic bones was very marked during extraction of head. Following delivery it was noted that there was a small tear of the skin just anterior to the urethral orifice, communicating with cave of Retzius. The self-retaining catheter was introduced through this tear in error. The tear was sutured with catgut and the catheter introduced into bladder under guidance of finger in cave of Retzius. One week later, patient complained of some backache which was controlled by strapping the pelvis. This pain would appear to have had its origin in damage to right sacro-iliac joint, which necessitated rest in bed for 20 days. On discharge patient has still*

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<sup>118</sup> In 1955 Zarate published his treatise on his sub-cutaneous symphysiotomy but was an influential obstetrician for many years prior to this.

<sup>119</sup> 2 pubiotomies were performed in 1944

<sup>120</sup> One of these applicants applied to the Scheme. It was not appreciated that a pubiotomy may have been performed until this audit. Radiology established that no pubiotomy had been performed.

*symptoms referable to right sacro-iliac joint. She has been fitted with a belt and is still under observation.”*

264. This type of detailed description was followed in all of the early cases. Later, in the mid-50s, the descriptions became more brief but the outcome for the mother and baby was always recorded and the reason for symphysiotomy was always provided.

265. The audits of the clinical reports for the NMH for the 25 years between 1943 to 1969 (after which symphysiotomy was extremely rare) revealed the following adverse events <sup>121</sup> were recorded against 338 symphysiotomies:

- 14 cases of incontinence
- 3 urinary tract infections
- 4 bladder injuries/trauma
- 5 fistulae
- 5 cases of haemorrhage
- 6 cases of vaginal and cervical tears
- 1 case of wound pain lasting 8 weeks
- 5 cases of wound infection
- 2 puerperal pyrexia
- 4 cases of pleural effusion/pneumonia:
- 1 case of thrombophlebitis
- 17 caesarean sections following ineffective symphysiotomy
- 3 vulval haematoma
- 1 temporary sacroiliac strain
- 1 back ache
- 2 cases of difficulty in mobilising
- 1 maternal mortality due to staphylococcal entero-colitis
- 32 gross fetal loss (15 stillbirth and 17 neonatal deaths)

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<sup>121</sup> A distinction must be made between adverse outcome and adverse event. Clearly a maternal death is an adverse outcome as is a loss of a baby whether before or after birth. Adverse events are of a much lower order and can be of a transient nature. Their recording is of importance in evaluating errors in treatment.

266. That breaks down to 26 cases with urinary issues and 4 possible mobility issues. The most serious of the urinary problems reported were the 5 fistulae which occurred in 1950, 1957, 1959 and two in 1963. The reports state that fistulae were repaired with good result in four cases but the 1959 case was recorded as having continuing “*troubling incontinence*” after the repair.<sup>122</sup> The cases of urinary tract infection and incontinence were described as *fully recovered* at the subsequent check up.<sup>123</sup> The case of back ache involved a number of adverse events and she *remained under observation*. The patient with difficulty in mobilising complained of pain in the symphysis wound which had *disappeared at 8 weeks*. The other patient still had SIJ pain at her six week check up and was fitted with a belt.

267. From 1944 to 1970 there were 128968 deliveries with a maternal mortality of 197 and a gross fetal loss of 6242 babies who were either still born, suffered premature deaths or were neonatal deaths.

268. 3332 caesarean sections were performed with 19 maternal deaths and 281 babies lost (75 stillbirths and 206 neonatal deaths). There were 53 caesarean hysterectomies.

269. Of the 68 applications of established symphysiotomy at the NMH: 25 applicants received awards for significant disability;

- Incontinence 2
- wide diastasis 12 (4 had some sacroiliac arthropathy and 1 showed evidence of earlier movement at pubic symphysis)
- back pain 5
- pubic pain 3
- fear of further pregnancy 2

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<sup>122</sup> Two of these patients were applicants. In one, urinary difficulties were not prominent and in the other, the problems continued throughout her life.

<sup>123</sup> Many of the cases of vaginal and urethral tears were associated with “*difficult forceps deliveries*” rather than the symphysiotomy procedure itself.



- prolonged recovery due to other health issues 1

270. As we had no benchmark<sup>124</sup> against which to measure these adverse event figures, we looked at the Coombe, the Rotunda and the Lourdes Hospital reports to see how they fared and finally we looked at adverse events associated with caesarean section for the same four Hospitals.

## COOMBE

271. The general figures for the Coombe hospital from 1944 to 1970 were 76761 deliveries with a maternal mortality of 120 and fetal loss of 3724.

272. In the same period, 215 symphysiotomy procedures were recorded at the Coombe. JK Feeney, the Master at the Coombe for the period 1950 to 1956, provided the details of all symphysiotomy procedures carried out by him with the same candour as found in the NMH reports. The 1950 Clinical Report contains his experience of 11 of the symphysiotomy operations he had performed that year. He provided his reasons for the procedure and posed several questions relating to possible adverse events associated with the procedure for those considering symphysiotomy and provided answers based on his recent experience. He reported:

- 2 cases where the patients had caesarean section when symphysiotomy failed<sup>125</sup>
- 1 case when the body of the right os pubis was divided in mistake for the symphysis, discovered by post partum X ray due to gait concerns.
- 1 case of puerperal pyuria
- 1 vaginal laceration
- 2 puerperal pyrexia
- 1 puerperal gluteal abscess

<sup>124</sup> UK Hospitals did not report their outcomes with the same detail or self criticism

<sup>125</sup> The details were provided. In one "the size of the baby -11lbs 12oz - was underestimated" and in the other "the mother had concealed her age (38) and that of her husband (65). Her rigid cervix did not dilate. Caesarean section should have been performed in the first instance".

- 1 wound discharge after return home
- 1 slight 'drag' in early locomotion

It was reported that 8 of those 11 patients had delivered easily and spontaneously within one year of the symphysiotomy.

273. The temporal context of the 1950 review was a hospital where 5362 mothers were delivered in the three year period 1948 - 1950 when the first of the Coombe symphysiotomies were performed. 18 mothers died from childbirth related conditions in those 3 years, 327 babies were stillborn or died within a short time and 75 babies were hydrocephalic, anencephalic or had spina bifida. In the same period, 845 perineal lacerations were recorded. Giving birth and being born was undoubtedly a relatively dangerous journey in the period. Symphysiotomy did not appear to cause unusual morbidity in the context of baby losses or vaginal or perineal tears although 10 adverse events were recorded against 11 procedures. Clearly the importance for Dr. Feeney was that 8 of those patients had a normal delivery within a year of the procedure.

274. In 1951, Dr. Feeney reported on his experience of now 40 cases of symphysiotomy. He posed the same questions and provided his opinion and then summarised as follows:

*"We believe that symphysiotomy, performed in the carefully selected case, provides a certain method of overcoming disproportion in both present and future labours. We base this statement upon observation of the course of the outcome of labour before and after the operation; manual examination of the pelvis before and after; study of both pre-symphysiotomy and post symphysiotomy x-ray films; experiments on bony pelvis; follow-up of patients through subsequent labours and the experience of our colleagues in the National Maternity Hospital. [.....]. Perhaps we can summarise the place for symphysiotomy by saying that if the obstetrician should come to the conclusion that the extra room provided will enable him to deliver the baby easily and safely, then the operation becomes a reasonable one and*

*should not be unduly postponed. His conclusion however should be based upon full knowledge of the clinical details of the patient; upon his experience of previous cases and, if available, upon his interpretation of the x-ray films. If symphysiotomy should result in traumatic vaginal delivery, its purpose is defeated."*

275. He then asked: *Are there any remote sequelae of consequence?*

His reply:

*"The incidence of remote sequelae must be decided by follow-up over a number of years. Stress incontinence of urine due to injury to the supports of the urethra is a possible complication. So far, our 40 patients with one exception, either never lost control or quickly regained it. Dyspareunia has not been reported. Symphyseal pain and tenderness and stiffness have been transient. The possibility of pelvic instability and back-ache, caused by sacro-iliac strain must be investigated further before an opinion can be offered."*

276. In 1951 Report, adverse events were recorded as:

- 3 vaginal lacerations
- 1 puerperal pyuria
- 1 superficial fibres of sphincter torn
- 1 low grade pyrexia
- 2 incisions of the public bone
- 1 wound infection
- 1 stillbirth.

It was noted all mothers were discharged well, although 1 on follow up had pulmonary tuberculosis.

277. In 1952 Report, adverse events were recorded as :

- 1 laceration of vagina / cervix
- 2 urinary infections
- 1 peri-urethral tear
- 1 proceeded to caesarean section

- 4 neonatal deaths

278. Dr Feeney sets out *“We have encountered no case of post symphysiotomy dyspareunia. The vagina has not shortened and, even though the anterior vaginal wall may be in the stretch immediately after the operation, it regains in a short while its ‘fluidity’ of movement upon the underlying tissues. Neither have we met with difficulty in locomotion, pelvic instability or permanent stress incontinence. We propose, however, in cooperation with our colleagues in the National Maternity Hospital, to carry out a follow up investigation on these lines. This will require the services of a first rate and unprejudiced orthopaedic surgeon and such examinations as urethra-cystography (Jeffcoate)”*<sup>126</sup>

279. Of the 215 deliveries where symphysiotomy was carried out at the Coombe between 1944 and 1970, there were adverse events recorded in 56 cases<sup>127</sup>. The same issues arose as in the NMH, being:

- incontinence 1
- lacerations and tears of the vagina, skin, bladder and sub-urethra 22<sup>128</sup>
- conversion to caesarean section necessitating two scars 7
- wound infections or slow to heal 6
- haematoma 1
- haemorrhage 2
- accidental over-abduction of the legs 1
- anaesthetic issues 3
- UTIs 2
- puerperal pyrexia 9
- locomotion / gait interference 2
- sphincter tear 2
- os pubis incised 3

<sup>126</sup> We have not accessed this study

<sup>127</sup> In the '62 & '63 Reports individual details were not set out

<sup>128</sup> These injuries were often associated with the use of forceps before or after the symphysiotomy

Gross fetal loss was 17 (4 stillbirths and 12 neo-natal deaths)

280. Once one excluded the babies who did not survive the birthing process, the most significant adverse events associated with symphysiotomy and the use of forceps appear to be tear injuries which were individually described as slight or minor but nevertheless, 6 peri-urethral tears occurred. There was only one report of slight temporary incontinence. No fistula was recorded. There was 2 reports of a drag in early locomotion and gait not as free as expected<sup>129</sup>.

281. During the period 1944 to 1970, when there were 76761<sup>130</sup> deliveries in the hospital overall, with no maternal deaths associated with symphysiotomy but 19 maternal deaths associated with caesarean section, 280 lost babies through stillbirth and neo-natal deaths and 87<sup>131</sup> caesarean hysterectomies.

282. 13 applicants from the Coombe received an award for significant disability: incontinence (3); wide diastasis (6) and psychological / psychosexual (4).

283. There was no evidence that symphysiotomy produced high morbidity figures for mobility issues or for incontinence.

## **ROTUNDA**

284. Only 45 cases of symphysiotomy were performed at the Rotunda. These were between 1951 and 1976, 3 later of which (in 1968, 1971 and 1976) were performed during assisted breech deliveries to release the after-coming head. In the years between 1944 and 1952 when symphysiotomy was being performed in the NMH and in the Coombe, pubiotomy was preferred to symphysiotomy at the Rotunda and was performed 15 times

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<sup>129</sup> 1 of those cases was where the "accidental" pubiotomy was followed up but not established.

<sup>130</sup> Caesarean hysterectomy was extracted from overall peripartum hysterectomy figures and therefore do not include all such operations

<sup>131</sup> The recording of caesarean/peripartum hysterectomy was not always clear

in that period. When symphysiotomy was eventually adopted as a procedure for the treatment for moderate disproportion it was initially carried out after caesarean section as a prophylactic procedure. Other than in 1961 where a small sinus is noted to have appeared in the incision, there are no adverse events recorded for symphysiotomy over that period although there were 3 neonatal deaths.

285. A change in attitude in the Rotunda appears in the Annual Clinical Report 1963: The Master *“symphysiotomy is advocated in order to increase the pelvic capacity thus permitting vaginal delivery at that time, and it is suggested that the fibrous union at the site of the symphysis will expand sufficiently in future labours to permit vaginal deliveries on subsequent occasions. Presumably it is felt that this course is safer than performing c-section on the initial occasion and repeating the operation when necessary in the future... only very small danger”*
286. 1965 - Browne: *‘It might be postulated that failure in engagement of the foetal head at or before term leads to failure in Ferguson’s reflex which is important in the initiation of the onset of labour. Thus symphysiotomy performed before the onset of labour might be expected to be a highly successful procedure and in fact such an elective operation would seem the ideal place for symphysiotomy.’*
287. 1966: *‘Repeat C-section shows disproportion as the leading indicator. This remains reasonably satisfactory in a privileged community where c-section is regarded as being safe. It would not be acceptable in communities with less facilities where c-section is not safe and in such circumstances symphysiotomy should certainly be considered as being a superior method of management for disproportion.’*
288. There were no maternal deaths associated with symphysiotomy in the Rotunda although 3 neonatal deaths occurred. To view the context: over

the same period 1944 – 1970, there were 127187 deliveries in the hospital with a gross maternal mortality of 173 and fetal loss of 6033.

289. 5781 casearean sections were associated with 35 maternal deaths and fetal loss was 435 (132 stillbirths and 303 neonatal deaths) and 70 caesarean hysterectomies. The morbidities for the 15 pubiotomies were 1 haemorrhage, 5 pyrexia, 1 vaginal tear, 2 neonatal deaths.
290. 32 applicants claimed that they had undergone symphysiotomy at the Rotunda. 13 applicants were deemed to have actually undergone the procedure. One of those applicants died before an assessment could be made. The remaining 12 applicants received awards of which 1 was for significant disability<sup>132</sup>.
291. We did not find support in the Rotunda Annual Clinical Reports for the premise that symphysiotomy invariably causes incontinence or significant mobility problems leading to a life of pain.

#### **LOURDES HOSPITAL**

292. The one provincial hospital that prepared reports similar in format to that of the Dublin hospitals and especially that of the NMH was the Lourdes Hospital in Drogheda. That hospital was the venue for the largest number of symphysiotomies and, not surprisingly, therefore the venue for the greatest number of incontinence claims.
293. 346 symphysiotomies were performed in the period of 1952 - 1971 in the Lourdes Hospital with 39 further symphysiotomies in all between 1971 and 1980. The clinical reports from the Lourdes Hospital from 1952 (when they first began) to 1982<sup>133</sup> were examined for notation of post symphysiotomy incontinence and mobility difficulties. Dr. Gerald Connolly was the lead

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<sup>132</sup> A bad back that was attributed to symphysiotomy by her treating specialist in 1981.

<sup>133</sup> We were unable to obtain the 1982/83 Report.

obstetrician and in fact only consultant obstetrician for the period up to 1964. Dr. Spain and Dr. Barry from the NMH were visiting specialists and clearly influential in the practices at this sister hospital. In 1964, Dr. Liam O'Brien who was trained in the NMH joined Dr. Connolly. Dr. Michael Neary joined the staff in 1974<sup>134</sup>.

294. The outcomes described in the reports show that obstetric adverse events at the Lourdes were similar to those which occurred in the Dublin hospitals. Again there was nothing of those recorded outcomes which pointed to a pattern of pelvic instability, walking difficulties or incontinence. The events tended to be of a more serious kind before they were recorded in the Clinical Reports. Vaginal tears, back pain, stress incontinence, haematoma and scar infection tended to be recorded on the patient charts and on the next antenatal records. The recorded morbidities were 10 stillbirths, 8 neonatal deaths, 5 haemorrhage and 4 cases of incontinence following injury. There were no maternal deaths associated with symphysiotomy.
295. The figures for the Dublin hospitals usually were for the period up to 1970 when symphysiotomy had all but ceased. For consistency, we counted symphysiotomy procedures in the Lourdes up to the biennial report covering 1970/1971 although the procedure continued to be performed until 1982.
296. In that period, from 1952 to 1971, there were 38430 deliveries in the hospital, with a maternal mortality figure of 30 and fetal loss of 1362; there were 1081 caesarean sections performed with 4 maternal deaths and fetal loss of 84 (18 stillbirths and 66 neonatal deaths). There were 23<sup>135</sup> caesarean hysterectomies following haemorrhage for adherent placenta, uterine rupture or other causes and 3 other cases of haemorrhage which did not lead to caesarean hysterectomy.

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<sup>134</sup> Dr. Neary preferred caesarean section to symphysiotomy. There were almost no records of Dr. Neary carrying out a symphysiotomy.

<sup>135</sup> The figure for 1966/67 could not be confirmed



297. 161 applicants claimed to have undergone symphysiotomy including 9 applicants who claimed for pubiotomy or both procedures at the Lourdes Hospital. No case of pubiotomy was recorded on any patient file seen and no pubiotomy is recorded in the Clinical Reports. Symphysiotomy was established in 143 applications. 43 suffered significant disability.

The breakdown of significant disability is:

- wide diastasis 18;
- incontinence / urinary tract infections 5;
- pubic joint issues 15 (8 with abnormal findings which explained pubic discomfort / dyspareunia, 7 grossly abnormal joints with some iatrogenic components<sup>136</sup>)
- abnormal sacroiliac joints 1;
- psychosexual/psychological difficulties 4

#### **CONCLUSION ON AUDIT**

298. The audit of the Annual Clinical Reports showed that the morbidities associated with symphysiotomy were less frequent and less serious than with caesarean section in the same period. However, as caesarean section was at the time reserved for severe disproportion and for life threatening medical conditions like toxemia and placental insufficiencies where baby and mother were at risk, it would be unfair to make a simple unqualified comparison. The audit did not support the thesis that symphysiotomy gave rise to a high level of morbidity. It did not confirm any fear that I harboured relating to adverse events or outcomes suffered by those patients who had died or who for some reason did not apply to the Scheme.

299. While it is not disputed that recovery from symphysiotomy is painful and that some patients suffered joint disruption causing perhaps quite

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<sup>136</sup> This may provide grounds for the suspicion that trainee obstetricians carried out these operations under supervision

extensive ongoing pain and discomfort, the absence of any great number of adverse events recorded following symphysiotomy accords with my experience of the general absence of evidence to support the claims of pelvic instability, walking difficulty beyond the recovery period or urinary incontinence.

## **SYMPHYSIOTOMY IN CORK AND OTHER HOSPITALS**

### **CORK**

300. 95 symphysiotomy claims involved Cork hospitals. 72 claims were established.

301. In St. Finbarr's, 35 symphysiotomy claims were established. 14 were assessed at or only claimed 1A and 21 were assessed under 1B.

Of the 21 applicants with significant disability:

- 14 wide diastasis
- 2 urinary problems (3 in total, 1 with wide diastasis)
- 2 pubic joint abnormality (3 in total, 1 with wide diastasis)
- 2 back pain (3 in total, 1 with wide diastasis)
- 1 psychosexual difficulties

302. In Bon Secours, Cork, 20 symphysiotomy claims were established. 12 were assessed under 1A and 8 under 1B.

Of the 8 that had significant disability:

- 4 wide diastasis
- 2 urinary problems
- 2 sacroiliac joint abnormality

303. In Erinville, 16 symphysiotomy claims were established. 8 were assessed under 1A and 7 under 1B. 1 applicant died before assessment.

Of the 7 applicants that had significant disability:

- 1 urinary problems

- 2 pubic joint pain
- 3 sacroiliac joint abnormality
- 1 hip degeneration in context of severe congenital hip dislocation

304. Cork Hospitals did not prepare annual clinical reports in the manner of the Dublin hospitals although there is some evidence<sup>137</sup> that there were at least three clinical results meetings of the provincial maternity hospitals held in the Lourdes Hospital in Drogheda in 1955, 1956 and 1959. However, we were unable to locate any reports relating to these meetings. As applicants from the Cork hospitals of St. Finbarr's, the Erinville and the Bon Secours no longer hold records apart from the extracts from Birth Registers, assessing morbidities was more difficult.<sup>138</sup> Reliance had to be placed on evidence of complaints recorded in GP records and of investigations. It was not possible to make any assessment of morbidities recorded from any hospitals outside of Dublin and Drogheda.

#### **OTHER HOSPITALS**

305. The few applicants who underwent a symphysiotomy assisted delivery in other venues outside of Cork and Dublin were even more difficult to assess. However, they could not be either advantaged or disadvantaged by the lack of records. Once symphysiotomy was established by secondary means, their claims were assessed by reliance on GP or treating specialist records of their condition. In some instances, I spoke to the applicants myself. It was noted in those few cases that the history provided included descriptions of prolonged labour, a large baby and the use of forceps. If complaints of stress incontinence were in any way temporally associated with the symphysiotomy delivery, then a wide and generous balance of probabilities rule operated in favour of the applicant and significant disability was established.

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<sup>137</sup> From what was said at Transaction meetings.

<sup>138</sup> Full records were available for a small number of claims from the Bons Secours.

### **ST KEVIN'S**

306. 18 applicants claimed symphysiotomy or pubiotomy or both at St. Kevin's Hospital in Dublin. No pubiotomy was established. Symphysiotomy was established in 11 applications. 8 applicants were assessed under 1A, 2 applicants were assessed under 1B and 1 for symphysiotomy before labour 1C.

Of those 11 applicants, 2 suffered significant disability.

- 1 wide diastasis.
- 1 applicant had suffered a fistula and suffered chronic urinary tract infections.

### **ST COLUMCILLE'S**

307. 9 applicants claimed symphysiotomy at St. Columcille's Hospital, Loughlinstown, County Dublin. Symphysiotomy was established in 8 applications. 4 applicants were assessed under 1A, 2 were assessed under 1B and 2 for prophylactic symphysiotomy 1C.

- 2 had a wide diastasis.

### **GALWAY GENERAL**

308. There were 22 claims that symphysiotomy or pubiotomy was carried out in the General Hospital in Galway which became the Galway Regional Hospital. Records there were maintained and stored on microfiche. 20 symphysiotomy claims were established. 10 applicants received awards for significant disability including:

- 3 wide diastasis (including 1 applicant who suffered early urinary incontinence and severely abnormal SI joints)
- 4 sacroiliac joint abnormality
- 1 psychological difficulties<sup>139</sup>
- 1 very difficult subsequent pregnancy following pubiotomy

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<sup>139</sup> Case of shoulder dystocia – pre-existing psychological problems

- 1 neurological thigh pain

## PORTIUNCULA

309. 7 applicants claimed a procedure in Portiuncula, County Galway. In 4 cases, symphysiotomy was established and awards were made. Significant disability was established in 2 of these cases. Both cases involved extreme obstetric emergencies - shoulder dystocia in one and a trapped aftercoming head in breech delivery in the other. These emergency procedures led to a fistula with subsequent urinary issues including frequent UTIs in the case of shoulder dystocia. The other case involved an exacerbation of pre-existing anxiety problems.
310. The other venues where awards were made involved were Dublin (other than the 3 main hospitals), Kilkenny, Limerick, Louth (not the Lourdes in Drogheda), Galway (other than above Galway hospitals), Mayo, Leitrim, Westmeath and Waterford. Generally, the findings are not as robust as in the majority of cases due to absence of records and reliance solely on reports of scar evidence.

## CLAIMS OF URINARY PROBLEMS IN PLEADINGS

311. There follows an example of claims of urinary problems contained in legal pleadings. **These injuries were not found in any case which came before the Scheme.**
312. "The Plaintiff suffered serious personal injuries which were more particularly as follows:
- As a result of the symphysiotomy operation, the Plaintiff suffered urinary incontinence problems, chronic pain and attendant disability. The Plaintiff's symphysis pubis was severed. She was caused to bleed profusely at the time of the operation and her pelvis was caused to be permanently unstable; it was permanently unhinged and remains*

*unbalanced. In addition, the Plaintiff suffered damage to her urethra and bladder and she was caused to suffer lifelong and constant pain and discomfort.*

*From the time of the symphysiotomy operation, the Plaintiff has suffered intense pain in her pelvic area, her pubic symphysis, her groin and her back. Furthermore, the chronic pain that afflicts her has intensified and her health and quality of life continues to deteriorate as a result of the injuries she sustained.*

### SYMPHYSIOTOMY - DIFFERING TECHNIQUES

313. In researching the history of symphysiotomy and its reintroduction into the National Maternity Hospital in 1944, this lecture delivered by Dr. Alexander Spain, Master of the NMH on the 19<sup>th</sup> November 1948 was found. He starts by agreeing with Munro Kerr – the author of the authoritative book on Operative Obstetrics – A Guide to the Difficulties and Complications of Obstetric Practice - that there is a place for symphysiotomy in carefully selected cases of outlet deformity. Spain then advocated extending symphysiotomy beyond outlet deformity to cases where clinical judgement and radiological knowledge of the pelvis would inform that only a little more room was necessary the whole way through to allow a safe vaginal delivery. He recited that while symphysiotomy was not common in Ireland and Great Britain, Munro Kerr, Fitzgibbon, Davidson and Chassar Moir had all performed the operation which was still popular in Latin countries.
314. He went through the history of the popularity of symphysiotomy which was followed by its near demise<sup>140</sup>. The history which he repeats, is found in *Surgery in Obstetrics* (and a more extended version in Greig in his scientific paper of 1952 and repeated in so many papers on symphysiotomy since) that its demise was caused when the advocates of symphysiotomy simply overstated the safe limits of the operation resulting in some disastrous outcomes and its fall from favour.
315. Spain outlined that sulfonamides and penicillin had removed the main terrors of sepsis and that caesarean section therefore became a much safer procedure than it had been previously. He outlined what became a familiar theme: that a Caesarean section was to get one out of immediate difficulty but was not a long term answer to disproportion and that was the kernel of the advantage of symphysiotomy *“The obstetrician must look to the future. With rare exception few will have the temerity to advise a*

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<sup>140</sup> This same history is recited in almost all publications on symphysiotomy

*further trial of labour when section has already been carried out because of, or in the presence of, disproportion. So arises the bogey of the repeat section. I will readily admit that repeat sections, provided they are lower segment operations carried out by experienced operators will give good results. I have, within the year, done a seventh repeat section in which one could not see a uterine scar or an intra-abdominal adhesion.*

*It will however be a long time before such a method of delivery would be easily accepted by the profession or by the community at large. The results will be contraception, the mutilating operation of sterilisation and marital difficulty, matters often too lightly considered by the medical profession but of immense importance in any community, especially where the great body of any large number of the people subscribe to the Catholic rule. These considerations coupled with a growing interest in pelvic radiography and a healthy distaste of difficult forceps operations determined my resort to operations designed to enlarge the pelvis”.*

316. He described his first 10 cases spread over 4 years out of 14,000 hospital deliveries. All the operations were undertaken in the second stage of labour when the foetal head had become arrested in the midstrait of the pelvis or at the outlet during attempted vaginal delivery. He concluded that while pelvis enlarging operations would be of great value in pelvises in which there is disproportion in the midstrait and at the outlet, their benefit should not be confined to such difficulties. He recommended symphysiotomy for the pelvis which showed a transverse narrowing the whole way through to increase the available true conjugate by about 1cm and would improve considerably the shape of the fore pelvis.
317. He outlined the results in another 30 cases where the symphysiotomy was carried out before the patient went into true labour. He then described that very few morbidities were associated with the 40 operations. He described that *“difficulty in locomotion following the operation might be expected from instability or tenderness of the symphyseal joint or from damage to*



*the sacroiliac joints. In [only] one of my cases did instability of the symphysis present any difficulty. In all cases the joint is quite steady, there was palpable separation at periods varying from three weeks to two years following symphysiotomy. In a very few, tenderness about the joint caused slight difficulty in walking, but in no case did this symptom persist for more than two months. My experience coincides for that of Munro Kerr and Jellet who found that damage to the sacroiliac joint with resultant difficulty in walking does not occur save in badly selected cases”.*

318. He described one case where there was such pain where he felt that she was unsuitable for vaginal delivery. However, *“complete recovery in locomotion had taken place two and a half months after discharge from hospital.”*

319. He describes that pubiotomy and symphysiotomy are both major operations and, as such, should only be undertaken by obstetricians with good gynaecological experience, under first class conditions and after full evaluation of the circumstances. He described his technique as being a combination of the methods employed by some of the Italian operators and that of Zaraté with some personal modifications:

#### **DESCRIPTION ALEXANDER SPAIN**

*The patient is placed upon the operating table with thighs flexed and slightly abducted. Her pelvis rests upon a specially designed corset, her legs are held by two assistants. A transverse incision from 2.5cms in length is made, just above the upper border of the symphysis pubis. The tissues are divided down to the lower border of the sheaths of the recti muscles. Any vessels which bleed in the superficial tissues are secured and tied.*

*The sheaths of the rectus are now divided longitudinally for about 1cm in the midline and transversely for about the same distance i.e. a small inverted ‘T’ incision with its base at the upper border of the symphysis*

*pubis. This will allow the index finger of the left hand to be introduced into the cave of retzius. It will be found that in most cases, this finger can be pushed down with ease between the bladder and the posterior surface of the symphysis until it reaches the vesico urethral junction.*

*An ordinary dissecting scalpel is now taken in the right hand and the superior and posterior ligaments and cartilage of the joint are divided by a nibbling movement of the point of the knife from behind forwards and from above downwards. The centre of oscillation of the knife will be about its point of entry. As the point of the knife returns from each nibble, the bladder is protected from any damage by the index finger of the right hand which is already in the cave of retzius. Its forward excursion is controlled by the left thumb.*

*When all the cartilage has been divided the joint will be noted to have opened from 0.5 to 1cm. Further opening of the joint depends upon division of the arcoid ligament. In most cases this can best be accomplished by getting the assistants to further abduct the thighs. Should this manoeuvre fail to give a sufficient opening, the knife must be reintroduced under the guidance of the left index finger and the ligament divided. A catheter placed in position before the operation has begun will serve as a useful guide to the urethra. This catheter, if used, should be removed temporarily as the baby is being born.*

*The operation is now complete.*

*It will be noted that handling of tissues per vaginam has been avoided. Down to the division of the ligamentum arcuatum the operation is almost bloodless. With division of the ligament there is sometimes fairly brisk haemorrhage, but it is venous in origin and in all cases, save one, stops spontaneously or was at least reduced to mild oozing. A small drain is introduced into the wound. Superficial tissues and skin are brought together. Should immediate delivery be contemplated, introduction of the*

*drain and suture of the wound are postponed until after the birth of the baby. A generous episiotomy is performed as the head begins to distend the perineum – this is the most important adjunct to the operation. It takes the strain away from the tissues of the anterior vaginal wall and the periurethral tissues which are now deprived of their bony support.*

*The catheter should be left in position for about four days. The patient is now moved out of the lithotomy position; the special corset is brought into position and fastened just comfortably. In earlier cases I used Elastoplast for strapping, it has many disadvantages from the point of view of the patient's comfort and it makes nursing difficult. Of course, it is worn during the puerperium. On discharge from hospital the patient is fitted with an ordinary corset for day wear. This should fit well-down below the trochanter. After discharge no special binder or corset is worn at night. All patients are given full doses of sulphonamides prophylactically. Patients may be allowed up about the tenth day.*

320. In the textbook used by medical students at the Coombe referred to by the late Maurice Neligan in an article in the Irish Times November 2nd 2004 –  
**A SYNOPSIS OF OBSTETRICS AND GYNAECOLOGY** By Aleck Bourne FRCOG and FRCS, 12<sup>th</sup> Edn, 1959, St Mary's Hospital in London:

### **SYMPHYSIOTOMY**

**Definition.** – An operation for the widening of the pelvic cavity by the division of the symphysis pubis.

**Indications.**–

1. FLAT PELVIS.–True conjugate not less than 3 in. (7.5 cm).
2. GENERALLY CONTRACTED and ANDROID PELVIS – The great increase in the transverse diameter renders the operation specially useful for this condition.

Operation is performed in the interests of the child in medium degrees of contraction, but its results in deliberate cases must be compared with those of caesarean section under similar circumstances. Chief indications in such cases: (a) Labour far advanced, with failure to deliver by forceps; (b) Reasonable chance of extraction of live child after operation.

It is necessary that : (a) Child should be alive, with good prospect of surviving delivery; (b) Cervix should be fully dilated.

Best results in multiparae.

**Operation.**—Special instruments are: symphysiotomy knife or blunt-pointed bistoury with cutting edge to the end, *Pinard's registering separator* for the pelvic bones.

Pass a bladder sound, and incline it to one side away from the midline. Incision, 3 in. long, in middle line, starting 1.5 in. above symphysis. Separation of recti and pyramidales at upper border of symphysis. Introduce the finger over the upper border of the symphysis to keep the bladder away from the tip of the knife.

Cut through the symphysis from above downwards, including the subpubic ligament, carefully sheilding the retropubic tissues by the fingertip.

The pubic bones usually spring apart about 1 in. (2.5cm.). Then introduce Pinard's registering separator, and encourage about 1.5 in. (4cm.) separation.

If possible, allow labour to terminate spontaneously, especially in a primapara, but apply forceps for foetal distress.

Assistants should be ready to support the ilia if the separation reaches 2 in. (5cm.).

During delivery take great care that the *anterior wall* of the vagina does not tear, as it is unsupported by the symphysis.

Anticipate such tears by free vulvo-perineal incisions.

After delivery, suture the anterior pubic ligament with silkworm gut – usually not necessary to wire the bones together. Afix a firm belt around the pelvis and keep in bed for four weeks.

**Dangers.**—Laceration of urethra, bladder, and anterior wall of the vagina.

*Haemorrhage* and sepsis.

Too great separation of the pubic bones, causing subluxation of the sacroiliac joints, and subsequent lameness.

**Prognosis.**—Wound usually closes by first intention. Some permanent widening of the pelvis generally follows. Locomotion is very seldom interfered with.

**Subcutaneous symphysiotomy.**—The indications of the operation are as above, but the actual division of the symphysis is performed by a sharp-pointed tenotome introduced from below behind the symphysis, cutting upwards.

No sutures are employed, and the prognosis is very good.

In the Textbook of obstetrics by **John F. Cunningham**, 4<sup>th</sup> Edition, 1962 he writes :

*“Until early in the 20<sup>th</sup> century Caesarean section was considered a dangerous operation, especially when performed following a long labour.*

*With improved surgical technique and with the advent of the lower segment operation, these objections disappeared. The operation became safer, it was easy to perform, the baby was delivered immediately and the infantile mortality rate was less. Caesarean section became the procedure of choice.*

*Nowadays, symphysiotomy is seldom performed in Britain and not at all in North America. It is used to a limited extent in Italy and Spain and is an established procedure in the Latin American countries. In Dublin it was revived by Spain at the National Maternity Hospital and is now being used at all three maternity hospitals[....] Since symphysiotomy apparently enlarges the pelvis, it has not been found necessary to repeat the operation at a subsequent labour – a great advantage over Caesarean section.*

*It is noticeable that in countries where the population is mainly Roman Catholic, efforts to perfect the operation have been sustained. Contraception and sterilisation are not countenanced by those who subscribe to the Catholic rule. Furthermore, many women who have no such ethical objections feel more normal and happier if they can have normal deliveries. These factors cannot be ignored especially in the light of the high level of safety of the operation at the present day.*

*In gross pelvic contractions Caesarean section is the correct operation. In lesser degrees of contraction and in the presence of certain abnormal presentations, where operative interference is necessary, the choice between Caesarean section and symphysiotomy lies with the individual obstetrician”.*

#### **ANATOMY OF THE SYMPHYSIS PUBIS**

*The disc of fibro cartilage between the pubic bones has the small central cavity lined by synovial membrane. The disc contributes little to the firmness of the joint which depends upon its ligaments, the strongest and*

*most important being the arcuate (sub-pubic) which lies under the pubic arch and is attached to the descending rami of the pubes and above the cartilaginous disc.*

321. He describes two methods of conducting a symphysiotomy :-

### ***The Open Method***

*The patient is put in the lithotomy position. An assistant should support her legs at each end. Under local or general anaesthesia a midline incision of 2 to 3" (6cms) long is made ending about half an inch short of the clitoris. The subcutaneous fat is divided to expose the joint and the lower end of the rectus sheath. For the division of the joint an ordinary scalpel is used. The front of the symphysis is felt for the exact position of the disc; the centre of the joint does not always correspond with the skin markings and is often difficult to locate.*

*Using the point of the scalpel, the front of the symphysis may be probed until the point is felt to sink into the disc. The blade is now turned in a forward and upward direction and a small portion of the anterior and upper surface of the joint is incised – this incision being carried for about half an inch into the anterior rectus sheath (care must be taken not to cut too deeply or the bladder may be injured). The incision in the rectus sheath is lengthened a little with scissors. The left index finger is inserted into the opening and gently pushed between the pyramidalis muscle to reach the back of the symphysis. The loose cellular tissues offer no resistance as the finger descends until the arcoid ligament is reached. The blade is now inserted into the top of the joint with the cutting edge directed forward, the scalpel being almost parallel to and close up against the left index finger. This finger protects the bladder and must not be removed until the joint is severed. The scalpel should never descend below the protecting finger. With short sweeping forward movement each one extending lower, the joint is divided without difficulty.*

*When the lower end of the joint has been reached, it may be necessary to divide the upper part of the **arcoid ligament** before the bones spring apart a distance of 2 or 3cms (1"). A stitch will close the smallest incision in the rectus sheath and the fat and skin are sutured. Before closure some penicillin solution should be injected into the space of the retzius.*

*The symphysis having been divided, a belt or a many tailed binder is now applied reaching from above the umbilicus to the middle of the thighs. It must not be too tight lest it counteract the effect of the operation by pressing the pubic bones together. Some operators have found the binder unnecessary, but it comforts the patient.*

*There is nothing special in the after treatment. The binder, if used, is tightened to give support to the pelvis. It may be loosened or removed when required for toilet purposes and is left off about the sixth day. The patient is allowed to walk on the second day. The less fuss by the nursing staff, the sooner the patient will walk easily. She may be discharged on the 12<sup>th</sup> to 14<sup>th</sup> day and will have completely recovered by the sixth week.*

*The union at the joint is always fibrous and will soften and stretch at subsequent labours giving permanent enlargement of the pelvis resulting from the operation.*

### **Subcutaneous Technique of Zaraté**

*The subcutaneous method reduces the incidence of all immediate or minor morbidities, for example labial swelling, haemorrhages, wound sepsis, but it is not as easy for the beginner to perform. Neither method will be followed by injury to the urinary tract if the technique is exact.*

*The patient should be anaesthetised and placed in the lithotomy position. Her legs should be supported by two assistants whose duty it is to regulate the degree of abduction with one hand and keep up pressure*



*over the trochanter or iliac crest with the other thus controlling the separation of the dividing joint. The catheter is passed and left in situ.*

322. *A small incision is now made above the upper margin of the symphysis. Through it an ordinary scalpel is pushed down to the front of the joint. The blade is then turned forward and made to enter the joint on its upper surface by a series of rocking movements. The upper and anterior portions are severed together with part of the arcuate/arcoïd ligament leaving the last fibres to be gently torn by slow abduction of the legs. By further abduction of the legs, the separation of the pubic bones to the allowed extent is brought about.*

*The forefinger of the left hand remains in the vagina to push the urethra to one side and also to give warning when the knife is almost through the joint and to ensure that the point of the knife is not pushed too far down. Once competence is gained the operation may be carried out under local anaesthesia. One suture is sufficient to close the incision.*

323. **Symphysiotomy - A Study Based on Eleven Personal Cases** D. S. GREIG, M.D., F.R.C.O.G. Consultant Obstetrician and Gynaecologist to Falkirk and District Royal Infirmary and to Stirling Royal Infirmary *Journal of Obstetrics and Gynaecology*

324. This study relates to 12 cases carried out in Scotland in four years. The author believes that *“there is a place for the operation when it has performed in the right case it gives a satisfaction rarely equalled.”*

Greig continued:

*Spain first and now Barry have succeeded in widening the scope of symphysiotomy. They have the special circumstances of treating an almost solidly catholic population and they are in hopes of averting many sequences of repeated Caesarian operation when the pelvic contraction is not too extreme. Similarly in Latin America and in continental Spain the*

*obstetricians there have their own special reasons for avoiding caesarean section. Aynie 1949 from Madrid reports that the incidence of voluntary infertility after Caesarean section is at least 50% and quotes other authorities which place it as high as 70%. Ramos from Buenos Aires reports the incidence as 50%. These workers have therefore a strong incentive to apply symphysiotomy after which operation the pelvis is permanently improved in capacity and subsequent labours are very frequently spontaneous.*

325. Greig recommended the procedure in the following circumstances:

- 1. When the engaged head is arrested by mid-pelvic or outlet contraction*
- 2. The engaged head is arrested in an abnormal presentation as face or brow*
- 3. Breech presentation*
- 4. Disproportion at the brim.*

*The operation, as I have practiced it, is based on the recommendations of Alexander Spain. As modified to suit my own instruments and hands, I find that my operation is near that of Zaraté and can be described as a partial symphysiotomy leaving intact the arcuate ligament and as much as possible of the lower third of the posterior ligament of the joint. The anterior clothing of the joint by the interlaced decussation of fibres derived from tendons of adjacent muscles, especially of the rectus abdominus and external oblique muscles, is left intact as far as possible.*

*The patient is placed on the table in a semi-lithotomy position. The legs are held by two assistants who sit firmly braced against the sides of the patient's pelvis; the thighs being maintained at about 45% flexion and about 30% abduction. The pelvis rests on a symphysiotomy corset. All but one of my cases have been conducted under spinal analgesia. When immediate delivery is indicated, it is an advantage to leave the obstetrics forceps in position.*

*A transverse incision of about 4 cm long is made just above the upper border of the symphysis pubis and the tissues are divided down to the rectus sheaths. This is the only part of the operation where any bleeding is encountered and superficial vessels may occasionally have to be secured. The rectus sheath is divided longitudinally upwards for nearly 2 cm and transversely in each direction at the upper border of the symphysis for 1 cm. These incisions must be made cautiously as the bladder and urethra may be very closely applied to the upper border of the symphysis at this stage of the operation. Left index finger is then pushed readily into the space of retzius between bladder and symphysis. The finger is pushed right down to the arcuate ligament and so displaces bladder and urethra backwards out of harm. Occasionally I have temporarily introduced 2 fingers behind the symphysis for the greater mobilization of these organs. If the head is very tightly jammed in the pelvis, an assistant can ease matters by gently pushing the obstetric forceps upwards and I regard the retention of the obstetrics forceps as a very marked help in this respect. The next step is to locate the joint and this step is by no means automatic. The joint is generally displaced slightly to the left and may be as far away from the midline as 1 cm. The joint is located by a tubercle on the superior border of the symphysis and by a ridge down the back of the symphysis. The knife must cut through the summit of both tubercle and ridge when cutting will be found to be very easy. If the exact centre of the fibrocartilage plate is missed, the cutting can be very hard work. The knife which should be a solid scalpel, is introduced on the flat between the index finger and the symphysis and then turned against tubercle and ridge. Care is taken to ensure that the knife is held exactly longitudinally. The scalpel is then firmly pressed forwards by the index finger in the space of retzius. It is an advantage to rock the scalpel slightly by depressing the handle backwards against the patient's abdomen. I find I can cut through the upper two thirds of the symphysis in one step. When this has been completed, the symphysis already opens to about half cm. The scalpel is withdrawn and the exploring finger feels for the upper edge of what is the left of the posterior ligament. In its upper two thirds, the posterior is flimsy and is of necessity cut; in the lower third of the symphysis the posterior*

*ligament is much stronger and its sharp edge can be readily palpated. I feel for this sharp edge and reinsert the scalpel just anterior to it and then complete the cutting of the fibrocartilage, working as always from behind forwards. During this process, the symphysis gradually opens to a full 1 cm and the index finger can readily feel the gap made. The scalpel is then withdrawn.*

*The assistants then flex the thighs to 90° and are required slowly to abduct the thighs to about 45° when the symphysis separates slowly to about 4 cm. This is generally an adequate gap. The abduction is done slowly and equally on two sides and the movement is checked by two fingers in the symphyseal gap. The arcuate ligament can be palpated in the depths of this gap and about 1 cm of the posterior ligament. I believe it is important to leave this ligament intact. It protects the vestibule from tearing by violence, just as a hem protects a handkerchief. It is also an insurance against severe haemorrhage from the vessels to the clitoris. This is an essential Zaraté principle.*

*In the conditions given above, the patient is ready for delivery. The chief effect of a symphysiotomy is the generous increase of the transverse diameters of the outlet.*

*After the whole delivery has been completed and the episiotomy repaired, a self retaining catheter is introduced. This will be allowed to remain in the bladder for four days. The patient is then restored to a dorsal position with the legs together while the symphysiotomy wound is secured by three or four deep silk sutures. The symphysiotomy corset can be then be tightly buckled and the patient returned to bed. The symphysiotomy corset is not apparently essential. Frank and Zaraté were content merely to tie the knees together. I think the corset gives greater comfort and gives the nursing staff more confidence in handling the patient. It can be omitted after four days and the knees tied together to the end of the first week. The patient is kept in bed for fourteen days and her ambulation is*

*generally satisfactory on her discharge after twenty one days. By this time the symphyseal gap averages about 1.5 cm.*

326. It can be seen that there were two schools of thought in relation to cutting or preserving the arcuate ligament. There seemed also to be two schools of thought among anatomists as to the role of the symphysis pubis and the consequences following division. There was the conventional wisdom in relation to the pelvis being a ring structure and that any interference with that ring causes disruption to the rest of the ring and thus pelvic instability and the school who base their views on research on cadavers including Zaraté and A.S. Sandstein and adopted by Spain, Barry, Feeney and Greig. Sandstein's research formed the basis of his Gold Medal MD Thesis in the University of Edinburgh in the early part of the 20<sup>th</sup> century and referred to extensively in a paper by Greig.

327. Sandstein concluded that *the danger of separation of the pubes had no reference at all to the sacroiliac joints. The only important ligaments for binding the bones together are the posterior sacroiliac and greater and lesser sacro sciatic ligaments. Disorganization or subluxation of the joint did not occur at any degree of pubic separation and that tearing of the anterior and superior ligaments only begins with a 7 cm. separation and then only in non-pregnant cadavers.*<sup>141</sup> Sandstein contended that *the transverse diameter of the brim was increased by 4 mm for every cm. of pubic separation and that the oblique diameter was increased by about 3 - 8 mm per cm.* These he stated were *worthwhile increases in a small round pelvis with inadequate transverse brim measurements.* He also stated that *the bladder and urethra are not affected by separation unless by an extension of a vestibular tear. Difficulty in locomotion is not a sequel to symphysiotomy.* As Greig stated *..Zaraté in the Latin American school bear this out ... as have Spain and Barry.*

328. Similar advice was received from the pelvic surgeon advising the Scheme.

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<sup>141</sup> Those ligaments are softer and stretch more in pregnancy and labour.

329. Zaraté also studied the physical changes to the internal dimensions of the pelvis by reference to physics. He was convinced that the pubic symphysis has very little influence on pelvic statics and that the sacroiliac articulations are the basis of the same on condition that they are not injured by any excessive or violent opening.
330. As far as I can understand the poor translation of **Zaraté's** method obtained at the RCOG Library is that he described his method as a partial symphysiotomy because the knife only opened the pubic symphysis partially and when the legs were abducted the separation continued gradually without the danger of cutting through any of the ligaments.
331. In an article published in the International Journal of Gynaecology and Obstetrics, Volume 23 1985, **Gorm Greisen**, a former District Medical Officer in Zambia, described eight symphysiotomies which were carried out in a small rural hospital in Zambia over a two year period. There were no maternal or infant deaths. Follow up after three years demonstrated the absence of long term complications. He followed the procedure described by Lawson and Stewart. He had no prior experience of the procedure. He described thus :-

*“With the patient in the lithotomy position a bladder catheter was inserted and the patient shaved. Local anaesthesia was used for the skin and pre-symphyseal tissues. Through a 1cm long incision of the skin, symphyseal cartilage was located with the tip of the scalpel.*

*While the urethra was pushed out of the midline by the fingers of the left hand, the symphysis was sectioned until the tip of the scalpel was felt through the vaginal mucosa by the left hand. First downward to the arcoid ligament which was not sectioned, then upwards. Assistants held the legs which were not allowed to abduct more than 30° from the midline. The vacuum extractor was reapplied, a wide episiotomy performed and the*

*delivery of the head controlled seeing that the symphyseal diastasis did not exceed the width of a finger.*

*After conclusion of the delivery, the skin incision was closed with one suture, the pelvis strapped with a bed sheet and the bladder catheter left in place. The patient was nursed on her side for 48 hours. The catheter was removed on the third day and the patient mobilised on the fifth day.*

*The patient was followed up regularly and all patients were found to be fully mobilised one month after the delivery. There were no urinary symptoms and Trendelenburg's test was negative. The seven patients examined between 2 to 5 years later were all in good health with only symphyseal pain on heavy lifting.*

332. The two methods of symphysiotomy are described in the current **German/Kenya Online Manual on Surgery and Labour.**

The chapter on symphysiotomy is prefaced by the following:-

*"This is one of the most contentious operations in this book. One school of thought considers it a "[...]barbarous operation done by expatriate doctors on the mothers of the developing world[...]" Another school, which includes all our contributors who practise obstetrics, considers it an invaluable operation which needs to be reinstated and given its proper place: (1) Unlike Caesarean section, especially with unskilled anaesthesia, it is never fatal, and seldom produces complications, particularly serious ones. (2) It does not leave a mother with a scar in her uterus which may rupture if she does not deliver in hospital when she is pregnant next time. (3) It may save her life if she delivers in a health centre and cannot be referred. Like many other medical procedures it has been evaluated by personal experience rather than by formal trials, and there is a particular lack of good data on how effective it is in the hands of paramedical staff on a community scale. We encourage you to investigate this, since, like the*

*destructive operations, it is one of the few practical procedures which might really alleviate maternal mortality from obstructed labour.*

*Symphysiotomy has fallen into disrepute because there was a time when it was used to overcome gross CPD, which led to serious complications. It is not used at all in parts of the world where CPD hardly exists, where trends are set[md]and where most textbooks are written. But, in countries where CPD is common, symphysiotomy is excellent[md]if it is used for borderline cases only. If CPD is marked, a mother needs a Caesarean section. The skill is to recognize the difference. You will not need to do a symphysiotomy very often, and you will find that deciding when to do one needs more judgement than deciding when to section a mother. If a symphysiotomy fails you can still do a Caesarean section: but you should look upon this as an error of judgement, and try to do better next time.*

*The indications for symphysiotomy in a hospital and a health centre are different:*

*In hospital, symphysiotomy is used to its best advantage: (1) At the strategic moment in a well-planned trial of labour, in which there is borderline CPD, and before there are any signs of fetal distress. If the indications are right, it is better than Caesarean section, and it avoids a difficult vaginal delivery. (2) In neglected obstructed labour it avoids a major abdominal operation in a high-risk mother. (3) It is occasionally useful in a breech delivery when the aftercoming head is arrested (9.8). Symphysiotomy is usually done in a primip, but you can do it in a multip. It is especially useful if a mother is isolated and cannot easily attend for antenatal care, if she is infected, and if your anaesthetic facilities are poor.*

*In a health centre a symphysiotomy is an emergency method of delivering a mother, and securing a live baby, when she cannot be referred. It should never be an elective procedure there, because she cannot have a Caesarean section in a hurry if she needs one.”*

333. There are two ways of doing a symphysiotomy, either: (i) **Open**



*“The advantage of the open incision is that it is large enough for you to see and feel exactly what you're doing.*

*Incise the skin and subcutaneous tissue over the symphysis pubis in the midline find the exact position of the cartilage of the joint.*

*Try locating it with the hypodermic needle first. Then use standard scalpel to cut down on it throughout its length. Clamp any superficial bleeding arteries. When you have exposed the joint throughout its length, divide using sharp solid scalpel or a standard one with a number two or 21. Cut it little by little with your right hand keeping her urethra to the side with your left hand. Mop up any blood.*

*When the joint is almost divided, it will begin to open. Continue cutting its fibres until it opens fully. 2 cm is ideal. It should never open beyond 3 cm or its infrapubic fibres may rupture spontaneously or need cutting. If separation is inadequate, cut more fibres, usually the superior and posterior ones. Do not use forceps after symphysiotomy as they may stretch the sacroiliac joints too much.*

*If she bleeds from the wound, watch out for haematoma. More likely with the closed method. Apply pressure.*

*Suture the subcutaneous tissue, vessels and skin.*

*Leave a self - retaining catheter in place for 48 hours provided her urine is not bloodstained and release it 4 hourly. Keep her in bed for 48 hours. Walking will be painful. Allow her to walk the fourth or fifth day.*

*Some patients can't do this easily, others especially the heavier ones, failed to walk until the fifth or seventh day. Remove sutures on the seventh day.*

*Most patients are walking well and fit for discharge on the 10th day. There is no need to bind her pelvis; her symphysis will heal and leave her pelvis larger than it was before.*

### ***Difficulties with open Symphysiotomy***

*If she has fever, suspect urinary tract infection due to the catheter.*

*If she is incontinent especially on standing, insert a catheter and leave it for two weeks. She will probably recover completely or partly. If she still*

*has trouble it is likely to be partial. Advise her to empty her bladder 4 hourly. Incontinence rarely lasts more than three months.*

*If there is bleeding suspect haematoma: this is said to be more likely when the closed method is used. If necessary drain.*

334. *Pain on discharge can be from chronic osteitis pubis, which is rare: Treatment is difficult. Treat her pain symptomatically. It probably only occurs when the incision involves bone. It is Important to keep strictly to the midline in the fibrocartilage of the joint.*

**(ii) Closed**

***Closed method of symphysiotomy*** is through an incision which is only just large enough to admit the blade of a scalpel. Opinions differ as to which is best. Of those obstetricians to do the operation, the large majority prefer that closed method and some think that we should not even have described the open one. One exceptionally able and experienced contributor, is strongly in favour of it. If you do the open symphysiotomy, you must divide the symphysis through its cartilage, exactly in the mid line because incisions which involve the bone to one side are more likely to lead to chronic pubic osteitis and long-standing pain, both of which are fortunately rare.

***Closed symphysiotomy*** is through a very small skin incision. Use an ordinary scalpel to cut through the skin and subcutaneous tissue in the midline. Then when you have found the cartilage, capture at exact centre with a solid scalpel or short ordinary one. Be sure to support the patient's legs and don't fail to insert a catheter before you cut.

335. **THE MOET COURSE MANUAL – *Managing Obstetric Emergencies and Trauma*** Published by RCOG Press 2007 27 Sussex place, Regent's Park, London NW1 4RG:

*Symphysiotomy is a relatively common procedure in the developing world, where it is used in situations of cephalopelvic disproportion when*

*caesarean section is not available. Symphysiotomy leaves no uterine scar and subsequent risk of ruptured uterus in future labours is not increased. Van Roosmalen illustrated the potential morbidity and mortality of caesarean sections carried out in developing country rural hospitals. Mortalities of up to 5% and an incidence of uterine scar rupture in subsequent pregnancies of up to 6.8% have been reported. Symphysiotomy has a low maternal mortality, with three deaths reported in a series of 1752 symphysiotomies. All three deaths were unrelated to the procedure.*

*Hartfield reviewed the cases of 138 women in whom symphysiotomy had been performed. Early and late complications were few and rarely serious if recommended guidelines were followed. He also reviewed published series of women followed up for 2 years or more after symphysiotomy and concluded that permanent major orthopaedic disability only occurs in 1-2% of cases.*

*Pape carried out a prospective review of 27 symphysiotomies performed between 1992 and 1994. Five women had paraurethral tears needing suturing, nine had oedema of the vulva or haematomas tracking from the symphysiotomy. All made a full recovery and severe pelvic pain was not a feature in any woman.*

*In 2001, the question of legal action against obstetricians in Ireland who carried out symphysiotomies was raised. Verkuyl made the point that many symphysiotomies were performed in Roman Catholic countries because contraception was illegal even for medical reasons and women were spared repeated operative deliveries.*

*Symphysiotomy is a useful technique that is occasionally required in UK practice. One report highlighted four cases where it has been used successfully in this country.*

*Bjorkland published a comprehensive retrospective review of the literature based on papers published between 1900 and 1999; 5000*

*symphysiotomies and 1200 caesarean section operations were included and the results indicated that symphysiotomy is safe for the mother and life saving for the child. Severe complications are rare.*

### **Indications**

- *Trapped aftercoming head of breech due to cephalopelvic disproportion.*
- *Severe cases of shoulder dystocia that do not resolve with routine manoeuvres.*
- *In cases of cephalopelvic disproportion with a vertex presentation and a living fetus (in the developing world), when at least two-thirds of the fetal head has entered the pelvic brim. Note that the use of forceps is contraindicated.*
- *In cases of cephalopelvic disproportion with a vertex presentation when caesarean section is declined by the mother.*

### **Technique**

1. *Place the woman in the lithotomy position with her legs supported by two assistants. The angle between the legs should never be more than 60-80 degrees to avoid putting a strain on the sacroiliac joints and tearing of the urethra and bladder.*
2. *Inject local anaesthetic into the skin and symphysis pubis. This step identifies the joint space and the needle can be left in place as a guide wire if the joint has been difficult to locate.*
3. *Insert a firm urinary catheter. Apply antiseptic solution suprapubically.*
4. *Push the catheter (and urethral) aside with the index and middle fingers of the left hand in the vagina. The index finger pushes the catheter and urethra to the side and the middle finger remains on the posterior aspect of the pubic joint to monitor the action of the scalpel.*
5. *Incise the symphysis pubis in the midline at the junction of the upper and middle thirds. Use the upper third of the uncut symphysis as a fulcrum against which to lever the scalpel to incise the lower two-thirds of the symphysis. Cut down through the cartilage until the pressure of the scalpel blade is felt on the finger of the vagina.*

*Remove the scalpel and rotate it through 180 degrees and the remaining upper third of the symphysis is cut. If a solid-bladed scalpel is available, this is better. If not, take great care with the standard scalpel blade, which is sharper. The symphysis cuts very easily; beware of going deeper and injuring the vagina or bladder.*

- 6. The symphysis should open as wide as the operator's thumb.*
- 7. After separating the cartilage remove the catheter to decrease urethral trauma.*
- 8. Use a large episiotomy to relieve tension on the anterior vaginal wall.*
- 9. After delivery of the baby and placenta, compress the symphysis between the thumb above and index and middle fingers below for some minutes, to express blood clots and promote haemostasis.*
- 10. Re-catheterise and leave a urinary catheter in place for 5 days.*
- 11. Apply elastic strapping across the front of the pelvis from one iliac crest to the other to stabilise the symphysis and reduce pain. The woman needs to be nursed on her side as much as possible with her knees strapped loosely together for 3 days. After this, mobilisation can begin.*

The method described in 2014 is not very different from the method described in the early 1950s.

**SYMPHYSIOTOMY FROM INTRODUCTION TO DECLINE – HISTORY THROUGH COMMENT AND PUBLICATIONS**

336. In Ireland of the 1940s, Caesarean section was associated with very real mortality and morbidity rates and was generally avoided unless the risk was warranted. Pubiotomy was occasionally tried as a method of addressing disproportion thus avoiding the risks of caesarean section.
337. Alexander Spain, the Master of the National Maternity Hospital was the first to re-introduce symphysiotomy as a possible cure for moderate pelvic disproportion and to some extent, as an alternative to pubiotomy. The first symphysiotomy procedures were performed in **1943-1944**. By 1948 2 or 3 other obstetricians were also performing the procedure. While the majority were slow to be convinced of the value of symphysiotomy being advocated by Drs Spain, Barry and Feeney, by 1951/52 it had become an accepted procedure in the Rotunda and in Cork, Drogheda and Galway.
338. The Annual Clinical Reports and the Transaction Meetings are major sources for plotting the rise and then decline of symphysiotomy. One can follow the growing acceptance of and the antipathy to symphysiotomy.
339. Towards the end of the 1960s, the procedure commenced its very rapid decline without any discernible *Damascene* moment. If one existed, then the evidence is not found in the Masters' reports or in the transactions. Something must have precipitated the abrupt abandonment of symphysiotomy by the Rotunda and Cork Maternity Hospitals in 1967 and by the greater body of obstetricians from the late 1960s onwards. During the same decade of the 1960s, maternal deaths associated with caesarean section had been falling steadily but while improving, fetal losses continued to be relatively high. In the mid-50s, the gross infant

death rate through stillbirths and neo-natal deaths hovered at about 10% and by the mid-60s was around 5%.

340. There is no evidence that symphysiotomy was giving bad or worsening results in the same period. Maternal deaths associated with symphysiotomy were nil until 1965 when one mother was lost. Fetal losses were lower with symphysiotomy than with caesarean section. In properly selected cases, a healthy baby was delivered vaginally and subsequent births were easy and without fear of rupture, adhesions, adherent placenta or haemorrhage leading to peripartum hysterectomy. It is accepted that in cases where the degree of disproportion was significant, the symphysiotomy served no purpose and the mother had to undergo two operations and thereafter could only deliver by caesarean section. There was no campaign against symphysiotomy; there was no adverse publicity causing its demise.

341. There is no obvious reason why 8 symphysiotomy procedures were performed in 1966 in the Rotunda and none thereafter. The change in attitude is intriguing. It is certainly true that the new Master Kieran O'Driscoll in the NMH was not enamoured with symphysiotomy and spoke out against it but the old guard nevertheless continued carrying out the procedure for disproportion in the NMH (27) and at St. Columcille's (2) during his Mastership - 1963 to 1969 inclusive. While the number of procedures was steadily diminishing, they were clearly still being carried out and reported on during his time in office. There was no dramatic rise in caesarean section rates or fall in the number of stillbirths and neo-natal deaths between 1965 and 1 January 1970 at the NMH. In that time 14 mothers died, 27,745 mothers were delivered, 911 babies were lost and 1083 caesarean sections and 12 symphysiotomies were performed.

342. While O'Driscoll spoke openly against the operation in 1966, he did not actually spell out why he was unimpressed with results apart from declaring that disproportion was a *mote in the eye of the obstetrician*. He

may have been engaging in a degree of hyperbole as clearly, disproportion did exist and continues to exist, as even the active management of labour cannot cure absolute disproportion. O'Driscoll was however very influential in his view that all healthy first time mothers should undergo a trial of labour with the liberal but measured use of oxytocics. If, under the new regime, the mother did not deliver within a certain pre-determined time, she underwent caesarean section. It may well be that this new regime was adopted with success in the Rotunda and in the Cork hospitals and that this was solely due to O'Driscoll's charismatic influence.

343. It could be for as simple a reason as better nutrition and living conditions led to slightly larger pelves or that warnings against the use of x-ray meant that fewer pelvimetry procedures were carried out with fewer advance fears of disproportion. As mentioned previously, it is very probable that a combination of factors worked together to render the procedure outmoded although it remained the operation of last resort to release the trapped head in breech deliveries and thus saved many babies who would otherwise have died.

344. One of the inferences could be that more babies were delivered vaginally when managed labour was introduced but the differences are small. The caesarean section rate in 1962/63 before active management of labour was in place was in the region of 2.5%. In 1968/69 when active management of labour was operational, the section rate was 3.7%. On the other hand, relative symphysiotomy numbers, which were always small anyway, were now only a fraction of that number. In 1962/63 31 mothers were delivered by symphysiotomy. In 1968/69 the number was 6. All it took was for 25 extra mothers to deliver vaginally or by caesarean section to skew the figures. Whatever happened, the symphysiotomy figures dropped dramatically in all hospitals, even in the Lourdes where the procedure continued to be carried out. It is very possible that the old guard was more influential with Dr Connolly of the Lourdes Hospital than



was Dr O'Driscoll. Whatever happened, it seems that new obstetricians seemed less concerned about mothers having large families and repeat sections than previously as they had access to legal anovulants while ironically, at the same time Catholic teaching on contraception hardened considerably<sup>142</sup>.

## **HISTORICAL DOCUMENTS**

345. The following quotations taken chronologically from the Transaction meetings and meetings held at the Royal Academy of Medicine along with some other materials, may accurately illustrate obstetrical attitudes in context of the time.

### **346. 1944 ACR, The National Maternity Hospital. Master Alex Spain**

Number of symphysiotomies 2

Number of Pubiotomies 2.

*"Though a small number of cases under this heading have appeared in my two previous reports, no detailed table was given. As I am now convinced that these operations have a small but very definite sphere of usefulness in difficult operative obstetrics, I have introduced a table this year. All the mothers and babies left hospital well, have been re-examined two months after delivery and have been found to have no ill effects.*

*It will be noted from the notes that three of these cases presented similar pelvic features at the outlet and in the fourth case there was narrowing of the mid-strait due to bulging of the acetabulum. All the babies were rather larger than normal.*

*It is interesting to note that in in the section table this year, there appears a case in which pubiotomy had been done in this hospital at her first confinement, which was followed by bony union necessitating section this time".*

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<sup>142</sup> The Papal encyclical *Humanae Vitae* restated the official line on contraception and included the pill in the list of prohibitions.

## 1945 Transactions

**E. Solomons** former Master at the Rotunda in the Transactions of the Royal Academy in **1945**:

“Why has the Master of the National Maternity Hospital brought back symphysiotomy into obstetrics in the face of unfavourable reports from other sources?”<sup>143</sup>

**AH Davidson** Master of the Rotunda in **1945**<sup>144</sup>:

“Reference shows that more than half of these (maternal) deaths occurred in cases of Caesarean section, a fact which should help to reduce the incidence of the operation and call for improved conditions for the patient’s safety when it has to be done. There are, however, already indications that the latter is being done, as the present Mastership is so far free from a maternal death in disproportion. This is the ideal to aim at but, I am afraid, impossible to attain, though there is no reason why the maternal death rate should not be less than 0.5 per cent.

Reference to the Table will show an undue proportion of foetal deaths under forceps, version, breech and craniotomy. Making allowance for those emergency cases brought to hospital with foetal death inevitable, it seems reasonably fair to draw the conclusion that in a large proportion of cases the wrong method of delivery was chosen...

It seems to me that the way to reduce infant mortality in disproportion is to choose our method of delivery in individual cases with more foresight and to carry out induction of labour and trial of labour only in those patients whose pelves are of such shape and size as to offer a reasonable chance of safe vaginal delivery for the particular infant concerned. The choice of such cases

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<sup>143</sup> Dr E Solomons, Rotunda Hospital, Discussions on the 1944 Dublin Maternity Reports. 1945 IJMS p565-556. The discussions do not refer to any response to this question.

<sup>144</sup> A Study of Disproportion in the Rotunda Hospital During the Past 40 years by Andrew H Davidson 1933-1940., 1945 Irish Journal of Medical Science p.90

involves a careful study of the pelvis by x-rays and of the fit of the head into the pelvic brim. The ability to arrive at a decision to terminate labour by section at an early stage in unsuitable cases is very important, instead of allowing an unequal battle to be fought for hours between the foetal head and the maternal pelvis.” <sup>145</sup>

#### **1945 National Maternity Hospital Annual Clinical Report. Master - Spain:**

“Symphysiotomy was done twice during the year. Both cases are of interest especially the “Booked Case”. In this case the operation was carried out in the first stage of labour after 36 hours trial had been allowed...Following symphysiotomy the pelvis was strapped and labour allowed to proceed, inertia still continued and persisted until 18 hours later, when the strapping was released. The head now entered the pelvis and labour was henceforth rapid, the baby being delivered by low forceps 6 hours later. Unfortunately the baby died on the 6<sup>th</sup> day – post-mortem examination showed septic pneumonia.

The second case was one of mid-transverse arrest in a patient who was admitted in labour with severe toxæmia, inertia and foetal distress. This baby suffered a tentorial tear, which had most probably taken place before the symphysiotomy was carried out, as delivery following the operation was very easy”.

#### **1946 Transactions**

At a meeting of the Royal Academy of Medicine in Ireland on **17<sup>th</sup> May 1946**, Professor Cunningham (UCD Medical School), stated<sup>146</sup>:

*“... The Caesarean section rate is terribly high in the National Maternity Hospital: here I must agree with Dr. Davidson. One cannot recommend it, especially on a young patient: in 1941 there were 40 Caesarean sections and in 1945 there were 82; that cannot be attributed solely to placenta previa. How can the Masters justify this high rate? Is it an attempt to prevent infantile*

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<sup>145</sup> A Study of Disproportion in the Rotunda Hospital During the Past 40 years by Andrew H Davidson 1933-1940., 1945 Irish Journal of Medical Science p.90

<sup>146</sup> Transactions of the Royal Academy of Medicine in Ireland , IJMS pp 599-602

*mortality? I do not seen anything to justify the high rate in any of the reports. If you have a high rate in the Dublin Hospitals you will have people practising elsewhere, with less experience, and may ultimately increase the maternal death rate”.*

In the same discussions, **Dr AP Barry** (National Maternity Hospital):

*“I think far too many sections are done, particularly in a young patient, for toxæmia or contracted pelvis. It is depressing for the woman in this country: in other countries they practice birth control. There is no blood bank in Dublin: there should be one established for the three hospitals and the Masters should get together to discuss this important matter.”*

In November **1946** Gallagher (National Maternity Hospital) :

*“Symphysiotomy has a very definite place in obstetrics, not only in the failed forceps case, but prophylactically.”*

**1946 Spain** (Master National Maternity Hospital):

[Pelvic radiography is] *“one of the greatest advances in obstetrics” “as great an advance as the introduction of chemotherapy in medicine.”*<sup>147</sup>

**1946 ACR, National Maternity Hospital. Master-Spain:**

“In this table will be found in detail the chief radiological features of the pelvis concerned and rather full notes of each case. In present day circumstances and with the more accurate knowledge of the pelvis that we can now achieve, the indications for the employment of this operation can be readily defined. A study of the 11 cases reported this year will show that in 4, Cases Nos. 12, 13, 16 and 19, the operation was elective. The results achieved have been very satisfactory in spite of 2 stillbirths in the group; a glance at the notes of the cases concerned, No. 16 and 21, will show that this fact cannot be correctly used as an argument against the employment of the operation.

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<sup>147</sup> *Transactions of the Royal Academy of Medicine in Ireland 22<sup>nd</sup> November 1946*

These cases have formed part of a communication to the Academy of Medicine, Ireland, on my experiences with this operation, which it is hoped will find publication in full later”.

**JK Feeney** (Master of the Coombe) wrote in **1947** in the Irish Journal of Medical Science<sup>148</sup> on failed forceps cases:

*“Pubiotomy and symphysiotomy gave excellent results: all 12 mothers and 10 of the babies survived. The only complications were one small peri-urethral tear and one morbid puerperium. No post-operative orthopaedic disability was noted and some of these women have had spontaneous deliveries since operation. Most remarkable, however, is the variety of abnormal pelves causing obstructed labour successfully overcome by division of the pubic bone or symphysis. Attention is directed to the patient who had a repeat pubiotomy, bony union having occurred after the primary operation. Pubiotomy, or better still symphysiotomy, would appear to be the ideal operation for certain cases of mid-strait and outlet contraction. If Caesarean section is performed for mid-pelvic obstruction in the first labour, the obstetrician who proposes to try to secure a vaginal delivery of a smaller baby in the subsequent labour is faced with the anxiety presented by a scar in the uterus and the continued presence of the pelvic deformity. Symphysiotomy will in a suitable case provide the means of avoiding the section in the first instance and of permanently removing the obstruction for future deliveries”.*

## **1947 Transactions**

**Feeney** at the Transactions of the Royal Academy Meeting of **1947**:

*“The Master of one hospital has reported favourable results with symphysiotomy (Spain<sup>13</sup>). In a limited number of cases, mid-pelvic and outlet*

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<sup>148</sup> Failed Forceps by JK Feeney IJMS 1947, p190

*obstruction in different types of pelves was successfully overcome by this operation, usually employed when traction with forceps had failed to effect delivery. Symphysiotomy provided the means of avoiding Caesarean section or a dangerously traumatic forceps delivery and of permanently removing the bony obstruction for future deliveries”<sup>149</sup>.*

#### **1947 Clinical Report NMH Master - Spain:**

“The operation of symphysiotomy was carried out in 9 cases without foetal loss. As the history of these cases and the chief characteristics of these pelves are of great interest, they are set out in much detail in the table. It will be noted that in 3 the operation was in the first stage of labour, in 4 in the second stage, and in 2 before labour has set in. Both the latter were multigravidae, 1, No. 20,910, had lost her first baby owing to bad features in the mid strait and at the outlet of her pelvis, in this pregnancy the presentation was a breech which resisted version, prophylactic symphysiotomy was followed by delivery as a breech of a healthy baby. The other, no. 24,677, had lost her first two babies, 1 stillborn and 1 neonatal death due to transverse narrowing of the pelvis combined with other bad features in the mid strait and at the outlet, symphysiotomy was carried out at 39 weeks followed by medicinal induction and the spontaneous birth of a healthy baby, weighing 8lbs 10ozs”.

#### **Feeney in 1948:**

*“We do, however, respectfully submit that the growing tendency to perform Caesarean section for indications other than major disproportion should be conscientiously reviewed from time to time in the light of maternal and foetal mortality rates, morbidity and invalidity. Within the limits of our own knowledge and experience, we are not at all certain that there is full justification for all the Caesarean sections which are being performed.*

*However, this may be, we must point out here that, considering the prevalence of contracted pelvis amongst the poor patients of this city and the large*

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<sup>149</sup> JK Feeney Caesarean Section in Dublin 1948, IJMS page 770

*numbers of abnormal cases of all kinds admitted from the city and country, the present Caesarean rate of about 3-5% indicates a reasonably conservative outlook, as compared with other centres".*<sup>150</sup>

## **1948 Transactions**

**Spain** at a special meeting of the Obstetrical Section of the Royal Academy of Medicine 10<sup>th</sup> December **1948** to discuss a report by Feeney on the position of Caesarean section in Dublin<sup>151</sup>:

*"On the other hand, the use of section in the treatment of disproportion is a very serious responsibility, especially in a community such as ours where the great majority of the population regard sterilization and artificial birth control as contrary to the natural law. Even though repeat section in many instances may be regarded as a comparatively safe operation, yet there is no doubt that it carries with it a more serious risk than vaginal delivery. In addition, owing to the fear of the operation that will arise in the parents' minds it may be calculated to give rise to much marital difficulty. The management of such cases, therefore, calls for very careful and experienced judgement. In the earlier years of my Mastership I favoured induction of labour, but gradually abandoned it in favour of trial labour. I am convinced that, in my experience, the latter is the better method of procedure..."*

*"It is important in considering figures of foetal loss to make certain that the neonatal death rate has been included. As a result of my 7 years' work on the place of symphysiotomy in the treatment of disproportion I am convinced that herein lies the answer to the great majority of cases of "failed trial of labour" in the young and fertile woman. There has grown up a belief in these countries that symphysiotomy is a very serious operation to be undertaken only in the occasional case of outlet contraction and then only as a last resort. The results of my work on symphysiotomy have shown that this view is fallacious, and that it is based on the fact that in the early days of this operation it was employed in*

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<sup>150</sup> Caesarean Section in Dublin by JK Feeney 1948 IJMS 755

<sup>151</sup> JK Feeney Caesarean Section in Dublin 1948, IJMS page 770

*all sorts of unsuitable cases and mostly in desperate situations. Careful radiography is of the utmost importance in the correct assessment of a suitable case. With a little experience it is easy to pick out those cases in which one can say that if trial of labour fails vaginal delivery can be safely accomplished following symphysiotomy, and furthermore there is the added satisfaction that one has in all probability solved the patient's obstetrical problem for all time".*

**James Quin** in the same meeting:

*"I am not in favour of prophylactic operations on the bony pelvis".*

**1948 Clinical Report, National Maternity Hospital. Spain:**

"This operation was carried out in 12 cases with 1 stillbirth. The stillbirth, No. 35345, took place in a patient who had been admitted after 50 hours labour which had been characterised by inertia. The cervix was incised bilaterally and an attempt made to deliver the baby without success, symphysiotomy was now carried out and the forceps removed for reapplication as they were judged to be badly applied, unfortunately, the cord prolapsed following the removal and despite the fact that they were reapplied at once and the baby delivered, it was stillborn.

The history of each case and the main features of the pelvis concerned are set out in the tables. Seven were performed after full spontaneous dilatation of the cervix. Two after the cervix had been divided bi-laterally a most useful operation in carefully selected cases. Three were done before labour. These latter 3 are of special interest. Two of these 3, Nos. 25531 and 26338, had been previously delivered by lower uterine section, 1 on two occasions. Both had been admitted late in labour in their first confinements, 1 being a failed forceps ultimately delivered vaginally of a badly damaged baby which did not survive, and the other being treated by section late in the second stage of labour. Following symphysiotomy both had easy labours with spontaneous deliveries of living babies weighing 8lb. 13oz. and 7lb 1oz.



I have, in all done 43 pelvis enlarging operations during my Mastership without maternal loss or permanent disability in excess of what would ordinarily be expected following spontaneous vaginal delivery. There have been 12 living babies born to these women in subsequent pregnancies. Thus, at least 55 sections for disproportion have been avoided. The operation has a far wider field of usefulness than my figures could indicate. An account of my experience which is at present in the Press will, I hope, convince many of this. That I have not employed it more frequently is due to the fact that it was an entirely new procedure to me and one that had to be faced against the weight of opinion of the entire English-speaking obstetrical world, an opinion which, I believe, with present day surgical technique and the knowledge we possess of the pelvis by radiography, to be ill conceived. I have good reason to hope that my successor will bring the use of this operation to its full scope”.

**1948 Clinical Report, The Coombe. Master- Edward A Keelan:**

“Symphysiotomy was done in 2 cases; both young primiparae, in which forceps failed owing to outlet contraction. There was 1 neonatal death after 3 days from intra-cranial haemorrhage”

**1949 TRANSACTIONS**

**P. Denham :**

*“Dr. Gallagher appears to condemn Caesarean section because it is associated with a large number of deaths. Of course it is, because it is used in dangerous conditions. It would be the same in any other branch of surgery in dangerous conditions. Brain surgery had a 90 per cent mortality rate, but it was not condemned for that reason, because the results would otherwise have been fatal”.*

**Quinn:**

*“His symphysiotomy results [Dr. Spain’s ] are excellent. It is an extraordinarily good operation and will help to reduce the high section rate. Dr. Spain will be*

*remembered by his insistence and gradual conversion to the early manual removal of placentas in cases of postpartum haemorrhage”.*

**Gallagher :**

*“At the Coombe I see that Dr. Keelan has done 39 new sections: I would suggest that he would do well to increase the number of inductions at the 36<sup>th</sup> or 37<sup>th</sup> week and also his number of symphysiotomies: in this way he could reduce his section rate. Sections in the Coombe seem to have been the major cause of death: 3 of the 5 deaths were either directly or indirectly caused by Caesarean section. Eight of the deaths in the three Reports have been caused by section, so that section seems to be the principal obstetrical cause of mortality in our Maternity Hospitals in Dublin.”*

**DR. R. Cross :**

“I do not share Dr. Gallagher’s enthusiasm for symphysiotomy.”

**1949 ACR, NMH Spain:**

“This operation was carried out 15 times with 1 neonatal and no maternal death (neonatal death, Case No. 23916, an error of judgment lost this baby. A symphysiotomy should have been performed as soon as the difficulty was encountered). The history of each case and main features of the pelvis concerned are set out in the table. A follow-up of these patients shows that this operation can be done without maternal loss or permanent disability in excess of what would ordinarily be expected following spontaneous vaginal delivery. Furthermore, the operation has the advantage that it leads to a permanent cure for the disproportion. Four patients who had undergone this operation on a previous labour complicated by disproportion, came into the hospital this year and had easy spontaneous full-term delivery of living infants without incident or complication. Such patients had they been sectioned would, of course, have come in for repeat sections for their still existing disproportion. In other words, by means of this operation, it is possible to remove completely a major complication of child-birth. We are satisfied that it should be considered in all cases of disproportion except those of extreme degree or where the patient is a very elderly primi-gravida. We emphasise again that this hospital delivered over

4,000 patients in this year with only 2 new sections for disproportion. The abdominal delivery for disproportion means repeated major abdominal operations, or such mutilating and unethical procedures as tubal resections, etc. With this comparatively minor operation the case of disproportion is converted into a normal case giving rise to little or no trouble in subsequent labour. The boggy of residual complications such as, stress, incontinence, of locomotive difficulty, backache, etc., did not materialise. Of course, in extending the application of this operation, difficulties are bound to be encountered before the full limitations of the procedure can be appreciated. This, however, should not deter obstetricians from applying its benefits to their cases of disproportion. As will be seen from Case no. 25621, section can still be performed if necessary”.

#### **1949 Clinical Report The Coombe Edward A Keelan:**

“Symphysiotomy was done in one case – a primipara – in which forceps failed owing to outlet contraction. The infant weighed 8 lb. 14 oz”.

**1950** in the Annual Report for the Coombe Feeney provided a detailed assessment of his first 12 cases of symphysiotomy.

#### **1950 Transactions**

Professor Jeffcoate of the University of Liverpool at the Royal Academy special discussion on disproportion in October **1950**:

In the three Dublin hospitals in 1949, Caesarean section or symphysiotomy was carried out for disproportion only 117 times. Only 3 primary Caesarean sections were carried out for disproportion at the Coombe, and only 2 at the National Maternity Hospital. In 5 large maternity units in Liverpool not less than 350 Caesarean sections for disproportion are performed each year. I had always imagined that the high incidence of contracted pelvis in Liverpool, and probably in Glasgow as well, was accounted for in large part by Irish immigrants living in very poor circumstances. Yet the same stock living under similar social conditions in Dublin is apparently immune from contracted pelvis. The

difference may have a dietetic basis, or perhaps your atmosphere is less smoke-laden, but this is only conjectural on my part, and I hope the explanation is forthcoming in the discussion.

One factor in the lower incidence of difficult labour in Dublin is probably the higher proportion of multigravidae. In each hospital primigravidae form only one-third to one quarter of the in-patients. On the other hand, if there were many women of high parity, the incidence of dystocia might be increased”.

...

“In the three hospitals there were only 33 new Caesarean sections (excluding repeats) for disproportion in one year. This is almost incredible to anyone from Liverpool, where such a number might easily fall within the experience of each of a dozen obstetricians in one year.

Nevertheless, the high foetal loss in mid-forceps delivery suggests that a rather more liberal outlook on Caesarean section would have been beneficial to the results as a whole, and to individual mothers and babies in particular”.

...

“The extreme desire to avoid a second Caesarean section, even when the pelvis is contracted, is manifested in the National Maternity, not by induction of labour, but by a readiness to resort to symphysiotomy.

It is with considerable hesitation that I refer to this operation because it has already suffered much at the hands of “*armchair*” critics, and I have never seen or practised it. Nevertheless, I should say at the outset that I believe it has a place in modern obstetric practice, albeit a small one. Let it be accepted that many of its immediate dangers and complications have been reduced by attention to technical details and by the modern ancillary treatments, and that the often expressed fears of subsequent locomotor trouble have been proved ill-founded. Yet there remain several questions to be answered, and these are raised by the records of 15 cases from the National Maternity and 1 from the Coombe.

1. *Is it a certain method of overcoming disproportion?* Although following division of the symphysis labour, previously obstructed, may be completed spontaneously, this (sic) by no means inevitable. At least 6 of the cases described in these Reports still required forceps delivery, while breech extraction was carried out in one, and Caesarean section in another. That is, only half of them delivered themselves. In many the foetus was already distressed by the time of the operation, in some rotation or forceps delivery had already been attempted and failed. Babies already threatened with death are, therefore, offered a way of delivery which is not certain, and which in any cases involves risk of further injury or asphyxia. If Caesarean section can be regarded as an alternative to symphysiotomy, it at least offers the baby certain and immediate relief and, as a rule, does not involve further trauma. It is clear from the accounts that not only was one baby lost, but several others were born in a state of severe asphyxia. They must have caused the obstetrician much anxiety at the time, and it remains to be seen whether they sustained asphyxial necrosis of the brain cortex.

Bearing in mind the foetal risk, the accounts of many cases leave the reader horrified at the courage of the obstetrician. Six of the women concerned were over the age of 35, 2 had one live child each and the remainder none. Some had previously lost children from dystocia. Yet the precious babies of these relatively elderly women were exposed to long labours, repeated attempts at forceps delivery, symphysiotomy and possibly still another application of forceps after that. The fact that these babies survived is fortunate; it might well have been otherwise, and the taking of such risks is difficult to defend. In these women there is little force in the argument that by avoiding Caesarean section, the size of their family remains potentially unlimited. They are all approaching the end of their reproductive life and symphysiotomy might well have deprived them of one of the few children they are likely to have anyway.

2. *Is the bony pelvis permanently enlarged to a significant degree by the operation?* In women of younger age groups it is argued that symphysiotomy permanently enlarges the bony pelvis and thereby permits easy and unlimited

reproduction in the future. X-ray pelvimetry at the National Maternity shows that in fact the pelvis gains only to the extent of 5 to 10 mm, in its transverse diameter. This not very much, but may well be significant in some cases. In support of this argument it is pointed out that 4 women subjected to the operation in a previous labour had a spontaneous delivery in 1949, and Dr. Barry writes: "*Such patients, had they been sectioned would, of course, have come in for repeat sections for their still existing disproportion*". Would they? In the Dublin Hospitals in 1949 at least 25, and probably more, women previously sectioned for disproportion had vaginal delivery. In view of what had been said earlier about the factors of disproportion, the argument is illogical. Dr. Spain (1949), describing a series of 41 cases of symphysiotomy carried out in past years at the National Maternity, mentions that easy vaginal delivery took place in a subsequent pregnancy in 5. Again, the figure is so small as to be insignificant. Before any reliable conclusion can be drawn, we need to know what happens in the further confinements in many more of these women and, as in the case of Caesarean section, how many fail to have easy spontaneous deliveries.

3. *Does symphysiotomy encourage large families?* Since one of the arguments in favour of symphysiotomy versus Caesarean section is that it does not lead to limitation of family size by sterilisation or contraception, it may next be asked why so few women subjected to symphysiotomy have been reported as having further children.<sup>152</sup> Perhaps it is taken for granted; if not, we should have the figures. This is important because there is now evidence (Jeffcoate, 1948-49, and Steer, 1950) to show that long labour ending in difficult vaginal delivery is followed by voluntary or involuntary sterility in 30 to 50 per cent, of cases. The figure is rather lower if delivery is ultimately effected by Caesarean section, and much lower if Caesarean section is carried out after a shorter labour. I would suggest that many of the women whose deliveries are

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<sup>152</sup> This is not in fact accurate. Each of the hospitals in the Dublin School published figure for women who gave birth following symphysiotomy. Refer the Clinical Report of the Coombe 1951 in Appendix III to this Report where Feeney says: "It may be noted that of the 11 patients upon whom symphysiotomy was performed in 1950, 8 have had spontaneous easy deliveries" and the 1950 Clinical Report for the NMH which is reproduced in Appendix III to this Report. 'We wish to report a further 10 cases where symphysiotomy had already been carried out for contracted pelvis, who came in this year and had each one an easy, rapid labour and a spontaneous delivery of a living child.

described under the symphysiotomy table of the National Maternity will be far more likely to avoid further pregnancy deliberately than if Caesarean section had been carried out before either they or their babies were seriously injured.

1. Again, the assumption that repeat Caesarean section inevitably limits the size of a family is unjustifiable. It is true that sterilisation is customary at the time of the third operation, but there is really no need for this if the patient does not wish it. Six or 7 Caesarean sections carried out on the same woman are relatively common, and one of these is referred to by Spain (1949). Even if symphysiotomy will do all it is supposed to do it has still to be shown that 1 symphysiotomy, not to mention the 6 subsequent vaginal deliveries, is less dangerous than 7 Caesarean sections.

4. *Is symphysiotomy less mutilating than Caesarean section?* The question here is whether it is better to have a scar in the uterus or one in the symphysis and its surrounding ligaments, together possibly with others in the vagina, perineum and cervix. We have to envisage that although symphysiotomy may be followed by easy spontaneous labour without further injury, in the majority of cases deep episiotomy is necessary and often rotation of the foetal head and forceps delivery, which may be difficult. Moreover, at least 3 of the women treated at the National Maternity now have not only a scar in the uterus, but one in the symphysis as well. One lost her baby in the process of acquiring extra scars. Another delivered only a 5lb 12oz baby and the transverse diameter of her pelvis is increased by only 8mms. What method of delivery is to be adopted next time these women become pregnant?

I would suggest that if a woman with a Caesarean scar in the uterus cannot deliver herself vaginally with no more difficulty than can be overcome by an easy low forceps operation, the abdominal route should be chosen again”.

“The details of these cases of symphysiotomy deserve the closest and unprejudiced study. They reveal that in the hands of experts the operation still involves some risks and in these Reports haemorrhage, thrombosis, and

embolism, the old bogies, still appear. It is difficult not to conclude that in many cases this and other difficult vaginal operations were carried out with one object and one alone, to achieve vaginal delivery at all costs. Those who adopt this view would do well to count the costs. These include risks of injury to foetus, to perineum, vagina and adjacent tissues, to the urethra and bladder, and to the rectum and anal sphincter. It must be reckoned, too, that the mother suffers an increased chance of haemorrhage, thrombosis and embolism, while subsequently her fertility may be impaired either involuntarily or voluntarily.

Indeed, those who would have us believe that the performance of symphysiotomy instead of the Caesarean section fulfils their objective of ensuring future good reproductive function must produce figures to show that women who are subjected to symphysiotomy have at the end of the reproductive life as many healthy living babies as those whose contracted pelvis is treated by Caesarean section. Until this is done, and the evidence so far available suggests that it will be difficult to demonstrate it, symphysiotomy must surely be looked on as an emergency last-minute escape from unexpected trouble. It has no place in the treatment of the primagravida, or even the multigravida known to have significant contraction of the pelvis. It is not suitable treatment where disproportion has resulted in stillbirth or needed Caesarean section in an earlier pregnancy. Rather is its place in the multigravida in whom unexpected difficulty arises at the outset, where perhaps the baby is larger than anticipated, and where the obstetrician is caught out and fails to carry out rotation of a head situated deeply in the pelvis. Even under such circumstances Caesarean section is often better, but there is the occasional case in which symphysiotomy may be the right way out.

I would conclude, as I began, by emphasising that these comments are offered with diffidence and with a very real sense of my own obstetrical failures and weaknesses. They have been deliberately critical and provocative because I take it that that is what is expected of an outside observer. There is evidence in these Reports of much excellent work deserving every praise, but if, for the



sake of politeness, I had registered approval on every point I should be guilty of dishonesty.

...

#### **Spain:**

“Comparing the section rates of all the hospitals in this matter with those of many other large centres, we must congratulate the Masters on their achievements, and especially the Master of the National Maternity Hospital for his refusal to accept Caesarean section as the answer to the failed trial of labour. Perhaps he has allowed his enthusiasm to carry him along, but on the whole we must agree that his enthusiasm is justified by his results. The Master of the Rotunda, on the other hand, would seem to accept the position. *“The value of the lower segment Caesarean section operation in disproportion is,”* he says, *“well known”*. We must all agree that this is so and that the operation has improved enormously both the maternal and the foetal results, yet we must also admit that Caesarean section is an obstetrical failure in disproportion. The obstetrician is the man who should stand by whilst nature is fulfilled *per vias naturales*. When he resorts to Caesarean section he has failed to stand by, and how often also, outside Catholic communities, does he go further and destroy by mutilation one of nature’s most important functions?...”

“... This is the kernel of the matter; the obstetrician must look to the future.

Out of this feeling of frustration, and my experience (and I might add abhorrence) of what is so often called the *“difficult forceps”* operation, have eventuated what I believe will prove the long-term answer to the problem, viz., symphysiotomy. Nothing new, an operation which had fallen into disrepute, essentially through the fact that it so much antedated modern surgical and radiological technique and thus had become associated in many minds with the horrors of the past.

I determined to try it in cases of mid-strait or outlet failure. Success was immediate, and it soon became obvious that it was associated with no more maternal disability than would ordinarily occur in spontaneous or easy forceps deliveries. *“Dramatic is the operation of Caesarean section. But if you have*

*witnessed an operator making vain attempts to deliver the foetal head, visible at the pelvic outlet on separating the labia, and then seen him divide the symphysis you will be forced to admit that symphysiotomy is just as impressive, and it is so finished, so eminently suitable to the particular circumstances. It is 'finesse' in operative obstetrics of the highest quality, and quality is the only thing that counts". (Munro Kerr).*

Finding in symphysiotomy the answer to this type of case, it was natural to ask why even those few who, in English-speaking countries, had in recent years raised their voices in its favour, restricted its indications to outlet difficulty? Why, if it enlarged the diameter of the outlet to permit of easy delivery, would it not also enlarge the diameters the whole way through? So we studied the radiographs of our cases and found that, not alone will it enlarge the transverse diameter of the brim, it will also enlarge the conjugate by almost 1c.c., and it will improve enormously the share in the case of android fore pelvis and will carry forward the position of the greatest available transverse diameter.

In my last two years as Master I proceeded, with great caution, to put the matter to the test, and felt convinced at the end of my Mastership that the answer to the great majority of cases in which trial labour fails at the brim, as well as those in which it fails in the mid-strait and the outlet, lies in symphysiotomy. In the type of case in question we have before us all the data on which we have based our decision to allow a trial of labour, and we know that if a little more room is provided the head will come through. We should not, therefore, push the trial too far, especially when the head is arrested at the brim..."

"Whatever the future holds for us in obstetrics I feel that a revulsion will come about against the present all too free use of Caesarean section, with or without sterilisation, in disproportion. I hope and believe that the answer will be found in symphysiotomy, a comparatively minor operation, and one that not alone provides for the immediate confinement but also provides for all the woman's future confinements".

**PROF. J.F. CUNNINGHAM:**

“The mother should be delivered safely without damage and with her future obstetrical chances unimpaired. It is, therefore, very important from that point of view to avoid doing Caesarean section on the young patient, as this tends to impair her future child-bearing ability. I do not consider that doing three Caesarean sections on a young woman and then sterilising her is good obstetrics, nor is the wish of the patient an indication for sterilisation. Most cases of disproportion are due to pelvic deformity: if you can give the patient a normal pelvis by doing a symphysiotomy then this is the correct treatment, as she will then have no further trouble on subsequent deliveries. The number of cases being so treated is small, and it will take some time to prove this. Symphysiotomy, I consider, is suitable for certain types of case, and if these are carefully selected it will eventually prove to be suitable for a greater number of them”.

**GALLAGHER:**

“I think that Professor Jeffcoate has been misled regarding the incidence of disproportion, largely because of the excellence of the Reports. Disproportion is not as common here as in other countries, but we tackle the problem in a different way. The population being largely Catholic, contraception is not allowed and, therefore, we must regard Caesarean section as not being the answer to the problem.

We see a number of contracted pelves, but these are not grossly contracted as a rule. We have excellent facilities for x-ray pelvimetry, and, knowing that the grossly distorted pelvis is rare, we have therefore, adopted symphysiotomy as the answer to the problem here. That is why Caesarean section is comparatively uncommon in this country for such complications owing to the ethical problem involved. Contracted pelves seem to be more rare on the south side of the city, for it seems we do only one or two sections for contracted pelves in the National Maternity, whereas in the Rotunda they do a great deal more. The time is ripe to give symphysiotomy a further trial, and I am

convinced from experience that this is the answer to the problem in this country”.

**CROSS:**

“... I disagree with Dr. Gallagher and Dr. Spain: I would much prefer the Caesarean section to symphysiotomy. I can see no reason why a Catholic should not have a Caesarean section done with the same degree of care. Symphysiotomy was popular in Italy about 300 years ago, but was never popular in England, and is only coming back into favour here because Holles Street likes it! If the operation was fashionable and popular in 1650, it is now on its way out. We have here a record of 13,000 without any details of disproportion. A new table in the Reports is the solution to the problem and in the years to come we will get much more light on the subject than we have today”.

**PROF. A.H. DAVIDSON:**

“... But I disagree that Caesarean section is a mistake and symphysiotomy the answer to everything. I do not believe this for one moment. If this was so every clinic would be doing it. I did many pubiotomies, but only when they were the only way out of a difficulty. Induction of labour is still the answer to many obstetrical difficulties. My Caesarean section rate was 0.7 per cent, through my Mastership, and I induced labour in both primigravidae and multiparae. I had all the snags in trying to avoid sepsis, but these can be overcome today. Induction of labour is not such a bad idea, and I do not see how symphysiotomy is the answer to disproportion”.

**DR. R.M. CORBETT:**

“I was brought up in a school where we did many inductions of labour in primigravidae, but gave it up eventually, but reluctantly, because it was not reducing the Caesarean section rate. In other words, I was not good enough. The difficulty is to know when to induce labour in order to have the baby sufficiently large to survive and sufficiently small to come through. I should like to be alive in 20 years' time, for if symphysiotomy is really the success it is held to be then it would be a very nice time indeed for the obstetrician. The

operation would be performed early in life and then there would be no further difficulties for any of us!"

**BARRY:**

"Having been in an out-patients' department for a number of years I am quite satisfied that the victim of Caesarean section is a chronic invalid. I feel that there is no limit to the fortitude of certain women. Caesarean section, which is a major operation, should not be performed if there is another way out, and I am convinced that there is another way out. I agree with Professor Jeffcoate regarding the high N.N.D. rate in the city, and I would prefer to be more liberal with symphysiotomy than with Caesarean section, which compared with it, is only a minor operation. It can be done in a few minutes and is a cure for the disproportion. When symphysiotomy is done the patient has an unpleasant time until delivery, and there is no way of avoiding this, but it is better to do it too soon than too late. (Dr. Barry here produced four patients to illustrate that they have had no ill-effects from symphysiotomy). These four women can have spontaneous deliveries at home or in hospital as often as they like, and you cannot say that Caesarean section is the answer to disproportion after seeing these four cases".

" Then why not be satisfied with what we have, elective section and trial of labour followed by section where difficulty is encountered? Well, the word obstetrician means the one who stands between the woman and harm, and yet he is the one who blasts the married life of countless women by performing a section in the first pregnancy for disproportion. This is followed so frequently by artificial interference with conception, by induction of criminal abortion, by marked limitation of family, and finally by the removal of the capacity to reproduce by tubal ligation, etc., and in every centre where this is happening at the same time more and more children are being demanded. Each year greater attention is being paid to falling birth rate. To say the least of it, it would seem to be a highly illogical proceeding. Caesarean section for disproportion in this country (where the unethical procedures just mentioned do not take place) is followed by a series of major abdominal operations, at one-and-a-half to three

yearly intervals, the victim usually becoming a chronic invalid as the result of these repeated assaults on her abdominal cavity. *“There is no limit to the number of Caesarean sections a woman may have, especially nowadays with good surgical technique and the antibiotic umbrella”*. I hear this statement quite often and I really think the statement should run rather that *“there is no limit to the fortitude of a woman”*. Most of us obstetricians who blithely cut into abdominal walls for the third, fourth, or fifth sections have never even allowed a papilloma to be removed from our own abdominal walls. One hundred and twenty operations were performed in this city last year under the heading of disproportion, 17 at the National Maternity, 30 at the Coombe and 73 at the Rounda Hospitals. It would not be inaccurate to say that 110 of these operations could have been avoided with complete satisfaction to the mother and infant, and with the sure knowledge that all future labours would be uncomplicated.

...

“All cases of minor or medium disproportion should have trial labour. When labour starts, if the pains are good await dilatation; if the head fails to descend and vaginal examination confirms that obstruction is present, do a symphysiotomy and allow labour to proceed naturally. If early rupture of the membranes take place, especially if there are no pains, or inertia occurs, do a symphysiotomy at once. In other words, the proper management of disproportion simply requires the substitution of the minor operation of symphysiotomy for the major one of Caesarean section. Wherever one has been told or one reads that section is indicated under these specific circumstances for the case of disproportion, change that to symphysiotomy and you will have very satisfactory results. The result will be a vaginal delivery with a permanent cure of the disproportion, and all future labours will be natural and without incident. It is easy to know when to do the operation: do it when section would otherwise have been employed, but be even more generous in your indication. Interfere early; it is only a minor operation and never has to be repeated. Even if for some added reason you have to follow this with a Caesarean section no harm will have been done; and you will still have cured

the woman of her contracted pelvis, and in her next pregnancy she will be able to have a vaginal delivery instead of a repeated abdominal operation.

One complication occurs more frequently than in normal delivery, viz., stress incontinence. If attention is directed to this early in the puerperium it can be easily controlled. Look at these women now and ask them have they any backache, any stress incontinence, or any difficulty in walking. I have done the operation on a number of women who have undergone Caesarean section after a failed trial of labour: all were reluctant to undergo the treatment, but when it resulted in vaginal delivery and when they realised that no further major abdominal operations would be required, they were all more than delighted. I do not yet know what limits should be placed on the operation. Of course, I am convinced that it is simply a matter of luck that we have not yet met a really dwarf type of pelvis with an average-sized baby, and I am satisfied that there are some cases where it would be wrong to do this operation, that we could not expect sufficient expansion of the pelvis to allow delivery without serious damage to the mother, but we so seldom meet these types of pelvises nowadays. The shape of the pelvis is not of very serious import, it does not matter whether the pelvis is flattened, transversely narrowed, male type, etc. Enlarge the pelvis, and the baby's head will fit through. Do not worry as to what particular diameter you are enlarging. I know that this may seem unscientific, but I have done it and it has worked, and I ask you to try it in your cases and I am sure you will find the same thing works. Again remember that what we offer is a *cure* for disproportion, not a treatment which has to be repeated with each pregnancy and which leads, as all thinking men will admit, to such wide and often disastrous effects on the child-bearing career of the recipient.

Chassar Moir has stated in a recent article: *"Although there can be no suggestion that symphysiotomy has a planned procedure in the treatment of disproportion, the operation does provide the obstetrician with the possible means of delivering a live foetus after a prolonged labour if a serious miscalculation has been made with regard to outlet contraction. Such cases of severe outlet contraction, unaccompanied by contraction elsewhere in the pelvis, are very rare, but when they do occur they cause severe obstetrical difficulty. Because the head is impacted at a very low level in the pelvis, section*

*is neither easy nor desirable*". He goes on to state that the danger is injury to the bladder, injury to the urethra, fistulae, disruption of pelvic joints. He further states that its only legitimate use is in this special and rare type of contraction. That it is only a means of escape from an impasse which would not have occurred but for a miscalculation on the part of the obstetrician. Had the pelvic abnormality been perceived in advance an elective section would have been the operation of choice. Now if you study these words carefully you will realise that under no circumstances can you accept the advice of the modern obstetrician in relation to symphysiotomy: he has not done it and he relies on telling you the disasters that occurred 30-40 years ago, or if he has performed it, he has simply performed it for the very unusual and odd case of outlet contraction without brim deformity. What more futile advice could we get than to be told that if we could discover the outlet deformity before labour, even though the brim is normal, that we should do a Caesarean section. Is this not the negation of the modern approach – trial labour? Try a symphysiotomy and you will find it a satisfactory cure of practically every variety of disproportion except cases of extreme pelvic deformity. Try it once and you will be satisfied, but do not condemn it without trial. I am not against Caesarean section *per se*; I am only anxious to save women from repeated abdominal operations and to help them to have their babies naturally. I know no more satisfactory treatment for many of the more serious obstetrical difficulties than section, but it is not the answer to disproportion in the young patient. In the last decade of the 19<sup>th</sup> century Lawson Tait advocated section as a treatment for placenta praevia and he was scorned by the obstetric world. In the early forties of the 20<sup>th</sup> century our eyes have suddenly opened to the enormous boon section confers on the case of placenta praevia. I hope you will not take fifty years to extend the benefits of symphysiotomy to your patients".

**1950 ACR National Maternity Hospital. Master - AP Barry:**

This operation was carried out 20 times. There was no maternal death, but 5 infants were lost, 3 stillbirths and 2 neonatal deaths. One neonatal death, No. 39662, was due to infection, and the mode of delivery cannot be blamed, the



other neonatal death, No. 40640, was due to intracranial haemorrhage and resulted from allowing the second stage of labour to last too long in the hopes of obtaining a spontaneous delivery. The 3 stillbirths were due to failing to carry out the operation in time, Nos. 39755 and 39905, and to attempting the operation in unfavourable circumstances, No. 40653.

The bladder was injured on 3 occasions in 2 cases, No. 38572 and No. 39622, the injury was the result of errors in technique and an immediate repair was effected without untoward result. We are glad to report that 1 of these cases, no. 38572, has recently delivered spontaneously a full-term normal infant without difficulty or injury. In the third case, No. 38607, the injury must have resulted from necrosis of the anterior wall of the bladder, due to the organ becoming nipped between the divided symphysis. Catheter drainage lead to prompt closure of the fistula.

In Case No. 38572 the operation was performed unnecessarily, a small hydrocephalus having escaped diagnosis, and in Case No. 40653 the disproportion was too severe and section should have been performed at the outset. However, a careful study of Case No. 38844 should convince even the most adverse critic of the benefits of the operation.

The history of each case and the main features of the pelvis concerned, are set out in the table. A follow-up of these patients shows that the operation can be done without maternal loss or permanent disability in excess of what would ordinarily be expected following spontaneous or forceps delivery. Furthermore, the operation has the advantage that it leads to a permanent cure for disproportion. We cannot emphasise this fact too often, because the constant cry of the detractor of the operation is: "What will it do that a Caesarean section will not?" It is possible by this means to remove completely a major complication of child-birth, that is, a minor or medium degree of disproportion. We are satisfied that it should be considered in all cases of this type, except where the disproportion is of extreme degree or where the patient is a very elderly primigravida. By this comparatively minor operation, a case of disproportion can be converted into a normal case giving rise to no trouble in subsequent

labour. The obstetric world is beginning to accept the fact that the bogey of residual complications, such as locomotive difficulty, backache and stress incontinence, does not materialise, but still it refuses to accept that the operation has a place in the obstetric armamentarium. We wish to report a further 10 cases where symphysiotomy had already been carried out for contracted pelvis, who came in this year and had each one an easy, rapid labour and a spontaneous delivery of a living child. The average weight of the babies in these cases was 7lb., 1 child actually weighed 10lb. 3oz. There were no complications, these patients all expressed themselves as very well satisfied with the operation and did not complain of any difficulty in between their pregnancies or during the pregnancy following the symphysiotomy. Had they been delivered by section, there would have been no alternative but a repeat section. In other words, there are 10 patients who have been cured of contracted pelvis and even the strongest advocate of the Caesarean”

**1950 ACR. The Coombe. Master- JK Feeney:**

“Our personal experience of this operation is limited to 12 cases, of which the details of 11 are recorded in this report. In consideration of the indications for symphysiotomy, the following pertinent questions must be answered :-...”

*[Note: The Author assesses in detail, the issue of symphysiotomy by posing and addressing a series of questions on the issue of symphysiotomy. The report is lengthy and is addressed in Appendix III. The questions posed are set out below].*

1. *“Does it provide a certain means of overcoming disproportion?”*
2. *Is the operation safe?*
3. *Is recovery speedy?*
4. *Are there remote sequelae?*
5. *Which is safer – a scar in the symphysis or a scar in the lower segment?*
6. *What is the effect of long labour and difficult vaginal delivery upon subsequent fertility?”*

"In 2 cases, Caesarean section proved necessary after symphysiotomy, so these patients suffered scars both in their symphyses and lower segments. In one, the very large size ( $11\frac{3}{4}$ ) of the baby was underestimated. Division of the symphysis relieved disproportion at the brim (10.8 x 12.0 cms. with transverse far back), but anuria developed later whilst the cervix did not dilate beyond 2-3 fingers. In the other, the patient concealed her true age (38) and that of her husband (65). Her rigid cervix did not dilate. Caesarean section should have been performed in the first instance.

Attention is directed to the case in which the body of the os pubis, to one side of the mid line, was divided to mistake for the symphysis.

In the case in which the foetus was stillborn, the mother was infected and the baby in poor condition on admission. Caesarean section would not have saved the baby".

#### **1951 ACR, National Maternity Hospital. Master-AP Barry:**

This operation was carried out 18 times. There was no maternal death, but 2 infants were lost, both being stillborn. One of these was associated with hydramnios and severe cyanosis during anaesthesia, Case No. 40947. The other, Case No. 43497, resulted from an error of judgment in carrying out the operation too late. On 2 occasions, owing to difficulty in finding the point, it was found necessary to cut the bone. On 1 occasion, as a result of persistent inertia, section eventually proved necessary, Case No. 32757. We feel that had we carried out the operation at the very start of labour, this section would not have been required. A critical analysis of these cases will show how often the operation assists in overcoming inertia secondary to disproportion. In a number of cases intranatal pelvimetries were carried out, following the operation. Immediate improvement in the station of the head and configuration of the pelvis was noted in all cases. Case No. 43417, was shown to the

Gynaecological Club. On 1 occasion the operation was carried out in the primigravida with a contracted pelvis and breech presentation arrested at the brim. Seven other cases of spontaneous delivery are recorded where the operation had been carried out for obstruction in previous labours. All infants were born alive – 4 weighing 8lb. or more, 2 weighing 7½lb. or more , and 1 infant weighing 6lb. 2oz. A critical and careful analysis of these and other cases which we have published should convince most obstetricians that this is an admirable and satisfactory way of handling disproportion, especially in young women. One last point which we would like to emphasise in relation to this operation is that when the patient returns for her next delivery, the unwary and inexperienced may be trapped into considering that disproportion is present and that Caesarean section will be required if they are not sufficiently patient to allow some time in the first stage of labour for stretching and expansion of the fibrous tissue which now binds the two pubic bones together. Neglect of this elementary precaution, no doubt, is responsible for a number of statements that the disproportion returns following the operation. We have, as yet, had no case in whom the pelvis failed to open out to permit of spontaneous delivery on a subsequent labour”.

**1951 ACR, The Coombe. Master- JK Feeney:**

J.K. Feeney’s comments on the 16 symphysiotomies performed at the Coombe in this year contained a comprehensive discussion on the indications for performing a symphysiotomy. These may be found in Appendix II to this report.

*“ The incidence of remote sequelae must be decided by follow- up over a number of years. Stress Incontinence of urine, due to injury to the supports of the urethra, is a possible complication. So far, our 40 patients , with one exception, either never lost control or quickly regained it. Dyspareunia has not been reported. Symphyseal pain tenderness and stiffness in locomotion have been transient. The possibility of pelvic instability and backache, caused by sacro-iliac strain, must be investigated further before an opinion can be offered.”*

## **TRANSACTIONS 1951**

### **PROFESSOR C. SCOTT RUSSELL (SHEFFIELD) :**

“I scarcely feel competent to discuss with you symphysiotomy. Though I have performed it two or three times with benefit, I have in recent years preferred the lower segment Caesarean section. At the same time, I note the good results claimed by this method, and I will be interested to hear what has to be said in its favour. My main anxiety would always be that as a result of the operation the bladder or the supports to the bladder would be severely damaged, and I note such difficulties are mentioned in Dr. Barry’s Report. In one case I did, the urethra was practically torn free of its anterior attachments, and though eventually the recovery seemed satisfactory, appearances after delivery were most alarming”.

### **PROFESSOR CHASSAR MOIR (OXFORD):**

“Now, you may reply that the strong preference shown for vaginal delivery in a young woman is because it avoids a Caesarean section scar in the uterus with compromise of the woman’s obstetrical future.

Is it then your policy to sacrifice the firstborn baby, and to use its dead or dying body as nothing better than a battering ram to stretch its mother’s pelvis in the hope that subsequent brothers and sisters may thereby have (possibly) an easier entrance into this world? And do you maintain that a competent obstetrician cannot perform – and usually with very little difficulty – two, three, four, or even more sections in one patient? Or do you suggest that your patients really are such morons that they do not understand the need to return to hospital for subsequent Caesarean sections?

But you may answer: *“Ah, but our patients go far beyond three or four subsequent pregnancies; we have to reckon in terms of ten, twelve, or more, subsequent children, and for these women it is certainly not practicable to keep on repeating abdominal operations”*.

Now, we must face up to this problem. You may say – and with every right – that you do not, in your country, countenance any form of family limitation, unless it be abstinence from intercourse at certain times in the menstrual cycle.

But if you say that, you will also in fairness allow me to reply that those whose allegiance is to the Reformed Christian Church find nothing in our Lord’s teaching, as revealed in the Gospels, to make us suppose that we are not doing right for our patients by occluding the Fallopian tubes if there have been several previous Caesarean sections and provided that, after careful and honest thought, and in consultation with both the woman and her husband, it is foreseen that further abdominal deliveries will be dangerous to health or to life. Indeed, we may go further and say that in this belief we are supported – even prompted – by the larger ethical consideration which is clearly set forth, for example, in that new Testament passage – the very passage once used by Sir J.Y. Simpson in his battle for anaesthetics, which similarly were bitterly opposed one hundred years ago – *“Therefore to him that knoweth to do good, and doeth it not, to him it is sin”*. (James, iv, 17).

Now let us see how this difference in ethical outlook has caused Irish obstetrics to diverge from obstetrics in Britain and elsewhere. The National Hospital Report shows it. It is the extensive use of symphysiotomy, and the meagre use of Caesarean section.

There we read of one woman, aged 28, at term with a true conjugate estimated radiographically to measure only 8.8cms (less than 3½ inches). The uterus

probably indicated by its bulk an infant of not less than normal size, for the birth weight was later found to be 7 lbs 4 ozs. The foetal head was above the brim and was poorly flexed; the membranes ruptured during examination. Gross clinical disproportion was apparent. In face of these highly unfavourable findings a symphysiotomy was performed. Labour progressed for 24 hours. Profound foetal distress developed; a Caesarean section was performed and a deeply impacted head was extracted with difficulty. The foetus could not be revived. This is openly admitted to have been the test for the scope of symphysiotomy. But is this not a case of “*wishful thinking*” obscuring reason?

Case 39755 is another example of a foetal death after prolonged labour in the face of “*gross disproportion*” at brim level.

Later we read of a woman two weeks overdue, whose uterus must have been large, for the baby was later found to weigh 9 lbs. Membranes had ruptured 26 hours before admission. The brow was presenting. The head was flexed and Willett’s forceps applied. Three hours later the os was fully dilated; there was no further advance and tumultuous contractions began. Bandl’s ring appeared. Symphysiotomy was performed. The head was manually rotated and delivered with forceps. The foetus died after delivery. There was a tear in the bladder. Post-natal examination showed a wide separation of the pubis of 2.8 cms.

What can be said of such cases? Surely, this is not present-day obstetrics. This is a midwifery of darker times. This is the murder of infants. Do you tell me that such wanton wastage of human life is a thing to be condoned or explained away in the name of religion? I can only suppose that if there is an ethical doctrine behind this obstetrical practice it is the perversion of a logic that may have had a sound basis, but which, in the passage of time, and by looseness of thought, has become a contention detached from reality. If – and such is the case – we have safer and kinder methods at our call, is there real reason why we should not use them?

Let me make my position quite clear. I believe there is a place for symphysiotomy. I myself have used this operation in the past and am prepared to use it again in the future. In this favourable attitude I, and possibly Professor Scott Russell, differ from almost all other practising obstetricians in England or Scotland, the United States or Canada. But I think its place is a small one, and chiefly concerns contraction at the level of the ischial spines and outlet; in other words the typically funnel pelvis, with anteroposterior funnelling as well as transverse funnelling. Even then, I should not use it as an elective procedure, but only as a means of getting out of a difficulty the possibility of which had been overlooked either from neglect or misjudgement. In all other cases I should prefer Caesarean section, not only because I believe that symphysiotomy is, for a given degree of pubic separation, less mechanically effective for brim contraction than for low cavity or outlet contraction, but also because arrest of the foetal head at brim level is so eminently suitable for treatment by Caesarean section.

I gladly agree that in many of the cases in the National Maternity and Coombe Hospitals symphysiotomy has been used with remarkable success, and, be it noted, has been followed in several instances by subsequent spontaneous and relatively easy labours – an event which I can also record from my own much more limited experience. But my fear is that the operation, which is useful in a limited field, may become a dangerous operation, and may again acquire an evil reputation, by being used in wholly unsuitable circumstances”.

**S.J. BOLAND, RADIOLOGIST :**

“Any procedure which is designed to relieve disproportion – particularly in those cases which do not exhibit gross pelvic deformity – is entitled to serious consideration. Therefore I intend this evening to describe very briefly the



radiological changes in the pelvis following the operation of symphysiotomy. This operation was re-introduced as a method of dealing with certain types of disproportion by Dr. Alex Spain at the National Maternity Hospital in 1944. Since then it has been employed to an increasing extent by the present Master, Dr. Barry, and now by Dr. Feeney at the Coombe. It is not my intention – nor is it within my province – to discuss clinical indications, operative technique or to classify results. Each case has already been adequately dealt with in the Reports of the National Maternity and the Coombe Hospitals. I propose to report on the changes seen in the pelvis as interpreted by me, and to show you some examples of the effect of the operation on the various diameters of the pelvis.

I am dealing with a series of 75 cases – not a large series – but I think peculiar in one respect, that it is the first group of symphysiotomies that have been subject to x-ray control. No statistically significant conclusions can be drawn from these results – the numbers are too small – but at least there is encouragement to continue. At the moment this much may be said with confidence: (1) the operation increases all pelvic diameters; (2) this increase appears to be permanent; (3) in patients examined four years or more after operation, the pelvis does not appear to have suffered any further distortion. It is hoped by keeping check of these patients to obtain further information in the future with regard to end-results.

Little information is available from the anatomists concerning the amount and type of movement to be expected in the sacro-iliac joints. From our cases it would appear to me that the amount of disturbance is very slight and that the power of recovery from such disturbance is very great. A careful study of the films appears to indicate that when the symphysis is divided, three things happen: (1) the symphysis is greatly widened; (2) there is slight widening of the anterior face of the sacro-iliac joint; and (3) either the sacrum slides slightly forwards or the iliac bones are pulled slightly upwards and backwards. The primary result is widening of the transverse diameter of the pelvis, the amount of such widening being proportionate in the amount of separation of the

symphysis. Perhaps more important than this, the transverse diameter (by that I mean the widest available diameter in the pelvis) moves forward, in some cases changing what has been a pelvis of almost android type into one that might better be classed as gynacoid. The obstetrical conjugate apparently has not been altered in any case. Its measurements remain the same, but again the character of the fore-pelvis is altered: it becomes more concave, and thereby enables the presenting head to make full use of the diameter available. These changes appear to take place throughout the whole passage. As will be seen from the films, the alteration in the sub-pubic angle is quite remarkable. The measureable and significant changes take place in the transverse diameter. This measurement reduces during the puerperium, as will be demonstrated later. The amount of separation of the symphysis does not appear to alter between pregnancies, but it is again increased during subsequent labour. It has not been found possible to get all our patients back for review, but in those who have returned, no pelvic deformity other than the separation of the symphysis was observed”.

(A series of films was demonstrated).

In conclusion, may I say that from being highly critical of this procedure, I have become a convinced believer in its efficiency. I confidently recommend its adoption in suitable cases as a means of permanently relieving disproportion. As far as one can judge from this series, it does not cause any disability”.

**GALLAGHER:**

“One cannot condemn the operation of symphysiotomy. I consider Professor Chassar Moir’s contention to be wrong when he says there is little-place for symphysiotomy. I would say it is eminently suitable in certain cases of disproportion, particularly in the android type of pelvis in which the transverse diameter is too near the promontory to be available for the head. This operation does bring about marked increase of the “*available*” transverse diameter. One must remember that Dr. Barry, Dr. Spain and Dr. Feeney are feeling their way

with the new technique, and some mistakes are inevitable. Caesarean section is rarely done for a contracted pelvis in the National Maternity Hospital.

#### **CUNNINGHAM**

“The discussion has dealt so far mainly with the merits of Caesarean section as against symphysiotomy, with the ethics of sterilisation included. I was rather horrified to hear one Fellow of this Academy state that under different circumstances he would be prepared to sterilise patients who were suffering from pelvic contraction. This is not a matter of religion. It is one of normal Christian ethics. We, as medical practitioners, should hesitate to assume, either individually or collectively, the functions of a judge or jury in a matter of this kind. What right has any one of us to tell a woman that she should be sterilised, and what right has any one of us to perform that operation, even should the patient consent to it or demand it?

There will always be some cases of contracted pelvis that will require delivery by Caesarean section. There must be an even greater number that can be safely treated by symphysiotomy. The latter operation has the advantage that it does not require repetition. If the operation of symphysiotomy takes the place which I am satisfied it should occupy in the treatment of contracted pelvis, the necessity to induce labour for this reason will disappear.

#### **PROFESSOR E. STACEY (SHEFFIELD)**

“With the present safety of anaesthesia, resuscitation and antibiotics, Caesarean section is such a safe operation that its repeated performance creates practically no further risk for a second, third, fourth, or further delivery than did the first. Under these circumstances I can see no objection to repeat Caesarean section in cases of disproportion. The question of sterilisation does not arise at all, and indeed it is not either my or most of my colleagues practice even to contemplate this procedure when carrying out the operation. Indeed I

deprecate the practice of sterilisation just as sincerely as those people who practice it are sincere in their outlook. I do not agree that symphysiotomy will always eliminate a case of disproportion in a subsequent pregnancy. This to a large extent must be governed by the permanent degree of enlargement of the pelvis and the size of the baby. It might conceivably arise that Caesarean section would be necessary even after symphysiotomy. This operation, as well as version or induction, in cases of disproportion has a limited scope, and even though now safe each is an anachronism”.

**O'DONEL BROWNE (ROTUNDA)**

“I am sorry that I have been regarded by one speaker at the *“bad boy”* as I had not done any symphysiotomy during the year. I would do the operation when I consider it indicated on medical grounds, namely, when outlet contraction of sufficient degree is encountered unexpectedly. I do not consider prophylactic symphysiotomy justifiable, but possibly low mid-pelvic disproportion might be answered by this operation and an easier delivery completed in emergency with less risk of damage to the child. I wish it to be clearly understood that the operation of sterilisation is not performed in the Rotunda Hospital. In my opinion, the lower segment delivery, if compared with an equally large number of symphysiotomy deliveries, will yield a lower foetal maternal loss and damage rate. I accused myself of over conservatism in the use of Caesarean section in the earlier part of my Mastership. I regret that Dr. Spain picked up on the foetal loss in forceps deliveries in the Rotunda, and I believe the subject should be reviewed over a longer period. I am certain that delivery is indicated, conditions for forceps being fulfilled, when advance by natural forces has ceased.

**BARRY :**

“If you study these figures [referring to table of figures] you will see that we value the life of the foetus every bit as much in Dublin as elsewhere....”

“..... Professor Chassar Moir has been very busy quoting Scripture to us this evening. Well, the Devil can cite Scripture for his own purposes. It would, however, be better for his argument if he did not quote in error my most successful case. It is really most helpful of him to remind me of this case, No. 38844. I showed this patient to Mr. McIntosh Marshall when he was in Dublin as an extern examiner last year. I demonstrated the x-ray films and told him that I proposed to let the girl have a trial of labour and if she failed to overcome the disproportion we would do a symphysiotomy, and I assured him that it would permit of normal delivery. He told me at the time that if this girl delivered herself vaginally he would be firmly convinced of the benefits of symphysiotomy. He is in the hall tonight and can vouch for the accuracy of my remarks. You have only to read the report of the case to see how successful we were. I cannot, however, deny that I made serious errors of judgment. I carried out the operation in an unsuitable case. I waited too long before performing the operation, but then how often is one attacked in obstetrics for too early interference? .....

Mr. Stacey is quite incorrect in his statement that disproportion returns after symphysiotomy and that the patient will require section on the next pregnancy. It is easy to make these statements, but I would like cases to support them before I can accept them. I have experience of 45 primary symphysiotomies, and already some 25 spontaneous deliveries in second and, in some patients, third and fourth confinements have followed the operation. Unless Mr. Stacey has actual experience to contradict this I cannot accept his statement.

I would urge everybody to consider carefully what we have been attempting to do in Dublin. We have been attempting, and I think with fair success, to cure contracted pelvis. This method is the most logical approach to the problem. If it succeeds, then the patient has one troublesome confinement and all others are normal. With trial of labour followed by section one closes one's eyes to the

cause of the difficulty and to my mind sets off on the pathway to crude carpentry and jungle midwifery in the future”.

## FEENEY

**“Symphysiotomy** – We have referred to this in some detail in our Report. Our opinions are expressed with the reservation that our personal experience of the operation is now limited to about 30 cases and our follow-up to a maximum of 2 years. We have tried to steer a mid-course between enthusiasm and disregard. When Professor Jeffcoate was here last year, he asked certain questions which constitute a reasonable basis for discussion.

(a) *Does symphysiotomy provide a certain means of overcoming disproportion?* As a result of observation of the course of labour before and after the operation, of bimanual examination of the pelvis and of the study of x-ray films taken before and after symphysiotomy, we have come to the conclusion that it produces in the properly selected case an obstetrically significant increase in the transverse diameters of the pelvis at all levels from brim to outlet. The so-called “*give*” in the pelvis, which follows division of the symphysis, is truly remarkable and cannot be appreciated unless personally observed. In respect of relief of obstruction in the cavity and at the outlet, symphysiotomy has more than fulfilled what might be reasonably have been expected of it.

(b) *Is the operation safe?* If it is correctly performed and if the subsequent delivery is properly conducted, the risks of haemorrhage and of injury to the bladder, urethra and vagina are negligible. The one operative risk is that of damage to the supports of the urethra. We allow our patients out of bed after one week and home within a fortnight.

(c) *Are there remote sequelae?* So far we have followed-up our cases, remote complications are of no consequence. The possibility of their occurrence has been over-emphasised and exaggerated. We have not

encountered vaginal deformity with dyspareunia, or difficulty in walking after the puerperium, or troublesome backache. Even after easy vaginal delivery, patients may complain of symptoms on these lines. Tenderness over the divided symphysis clears up. Generally speaking, urinary control is satisfactory, but the incidence and duration of incontinence must be investigated by follow-up.

(d) *Which is the safer; a scar in the symphysis or a scar in the lower segment?* With symphysiotomy carefully selected, the young primigravida is safely carried through her first labour. In addition, she is provided with a permanently enlarged pelvis. Selected cases of dystocia in multiparae may be treated likewise. The operation is a minor one. The modern lower segment section is a sound and safe operation, but if it is performed for genuine cavity and outlet disproportion in first labour, it is almost certain that it will be repeated in subsequent pregnancies. In this country, then, let us consider the question – *“Which is safer: one scar in the symphysis or several in the lower segment?”*

So far, our patients are satisfied with symphysiotomy, and for ourselves it provides an easy way out of certain difficulties”.

#### **1952 ACR, The Coombe JK Feeney.**

Number of symphysiotomies      19

“In our fourth year of its trial, we are satisfied that in selected cases symphysiotomy has a definite place in the treatment of disproportion at all levels in the pelvis. Clinical experience and x-ray examination have revealed quite clearly that the operation is applicable to certain cases of brim contraction. We wrote at some length about its indications and technique in our Report for 1951. In 1952, it was performed on 19 patients. Attention is directed to the three cases in which the foetus did not unfortunately survive...

- i. Over the past 3½ years, included in our 60 cases, were many emergency admissions from hospitals and nursing homes. In a few of these, forceps had been failed by experienced obstetricians, but symphysiotomy resulted in easy deliveries. It is inevitable that occasional babies will be lost.
- ii. If the patient has already been anaesthetised for an attempted delivery and/or if the foetus is distressed, symphysiotomy may be performed under local. The actual “give” at the symphysis is, however, unpleasant.
- iii. In two cases (one reported here), we employed symphysiotomy as an emergency measure for difficulty with the head in a breech delivery.
- iv. The operation is of very real assistance in multiparous dystocia caused by large foetus in association with slightly contracted pelvis. Traumatic forceps, or dangerous internal version or Caesarean Section is avoided. In a previous Report, we expressed the view that secondary contraction of the pelvis due to forward obtrusion of the sacrum in its upper part, or even of the bone as a whole, may occur more often than we think. In this country, rapidly succeeding pregnancies with early resumption of hard work in the home must result in permanent stretching of the anterior and posterior sacro-iliac ligaments. After all, these ligaments become softened and elastic during pregnancy to as to permit what Monro Kerr aptly describes as “give”. X-ray films frequently show a “prominent” promontory with anterior tilting of the upper sacrum in grand multiparae. Apart from flattening of the brim, the “direction of passage” of the foetus through the pelvis must be altered.
- v. Young patients upon whom a previous section had been performed for minor/moderate contraction may, in selected cases, be relieved of their tight fit by symphysiotomy (Case 15).



- vi. We have encountered no case of post-symphysiotomy dyspareunia. The vagina is not shortened and, even though the anterior vaginal wall may be on the stretch immediately after the operation, it regains in a short while its “fluidity” of movement upon the underlying tissues. Neither have we met with difficulty in locomotion, pelvic instability or permanent stress incontinence. We propose, however, in co-operation with our colleagues in the National Maternity Hospital, to carry out a follow-up investigation on these lines. This will require the services of a first-rate and unprejudiced Orthopaedic Surgeon and such examinations as urethra-cystography (Jeffcoate).
- vii. Eight of the eleven patients, for whom symphysiotomy was done in 1950, have had spontaneous vaginal deliveries. Up to the end of June, 1953, six of our 1951 patients have returned.
- viii. One of the most satisfying experiences in obstetrics is an easy spontaneous delivery after the relief of obstruction by symphysiotomy and the still easier delivery in the following pregnancy. It may, however, prove desirable or necessary to complete delivery after symphysiotomy by forceps: if this should be so, the integrity of the anterior vaginal wall should be provided for, so far as is possible, by intelligent traction and episiotomy. Laceration of the stretched anterior vaginal wall does not occur with spontaneous delivery. If traumatic vaginal delivery should follow symphysiotomy, the aim of the operation has not been achieved”.

**1952 Barry** wrote in an Article “*Symphysiotomy or Pubiotomy Why? When? And How?*”

*“Symphysiotomy is preferable to pubiotomy for a number of reasons:*

- *The is only one incision well away from the area of contamination;*
- *Fibrocartilage is divided in symphysiotomy rather than bone with reduced danger of infection;*

- *The least vascular region in the pubic area is incised lessening the chance of haemorrhage;*
- *There was no danger of callus formation “increasing the pelvic contraction”;*
- *Performing a symphysiotomy was a much easier procedure than pubiotomy.*

Barry had carried out the symphysiotomy operation on 42 occasions.

*“When should the operation be performed? The answer to this is comparatively simple. The operation should be carried out: (a) in all young primigravidae with pelvic contraction undergoing trial of labour when the natural powers are failing to overcome the obstruction; (b) in all multigravidae with disproportion sufficient to cause obstruction; (c) in all cases of failed forceps due to contracted outlet if the child is alive; (d) in face presentation with the chin posterior and in brow presentation, where efforts at correction have failed; (e) in all young primigravidae with contracted pelvis selected for trial labour in whom early rupture of the membranes or inertia occurs. In such cases it is better to do the operation too early than too late, as delay may result in loss of the baby. The operation should not be employed unless the true conjugate is at least 8.5 centimetres. Size and moulding of the foetal head may occasionally alter this rule”.*

*“[...] That lower segment section is the most satisfactory and logical line of treatment in gross disproportion is not for a moment to be questioned, but in cases of minor or medium disproportion is not the relatively simple and minor procedure of symphysiotomy, if it allows of vaginal delivery for this and all subsequent pregnancies, the obstetric procedure of choice? That the operation does affect these results will be seen from a perusal of world literature and from an analysis of the cases detailed herewith”.*

*“[...] Again, it must be emphasised that the real value of this procedure is that it does not have to be repeated as does the Caesarean treatment of contracted pelvis. It may be argued that no woman need have more sections than she*

*freely desires, but in many countries and especially in those containing a high percentage of Roman Catholics, sterilisation and contraception are repugnant to the patients; here the young primigravida treated by section for contracted pelvis faces a future of numerous repeat operations. These in time may lead to such undesirable effects as disorganised uterine scars, uterine rupture, extensive abdominal adhesions, bladder injury, ventral hernia, and the serious effects of the fear of abdominal operation on marital relations”.*

*“[.....] its unhappy early history and the necessity of awaiting spontaneous delivery following its performance.”*

*“[...] It makes for salutary thinking to recollect that it took the obstetric world nearly half a century to follow the advice of Lawson Tait in the management of placenta praevia, and that Munro Kerr preached the advantages of the lower segment section for nearly as long before that operation received its proper recognition. On the one hand, when the trial of labour has proved the presence of obstruction, the condition can be cured by bringing about a permanent and stable enlargement of the pelvis; on the other, the cause of the dystocia can be ignored, the uterus incised and a similar problem anticipated on all further labours”.*

*“... The symphysiotomy belt may be tightened up firmly when labour has been completed, so that the patient may gain full benefit from its support. The belt is usually discarded in five or six days. The patient is allowed up on the tenth or eleventh day. No special corset or pelvic support is required unless the individual feels the necessity for it herself. Full painless locomotion will have returned within four to six weeks, often much earlier. Heavy weights should not be lifted for three months”.*

He discussed the potential complications arising from the procedure under the headings:

1. *Haemorrhage;*
2. *Uterine inertia;*
3. *Suppression of urine;*
4. *Failure to find the joint space;*
5. *Bladder injury;*

6. *Locomotive difficulties;*
7. *Stress incontinence.*

Conclusion *“permanent benefits conferred on the patient by the operation and the complete absence of long term complications.”*<sup>153</sup>

### **1952 ACR, National Maternity Hospital. AP Barry :**

We have now performed over 100 of these operations and after careful study of our successes and failures we are convinced that as a general rule Caesarean section is indicated only seldom in contracted pelvis (the elderly primigravida and the rare case of gross contraction). For the common type of contracted pelvis (unfavourable characteristics, or minor reduction in measurements) the correct treatment would appear to be trial of labour, followed if necessary by symphysiotomy. Again we wish to stress that after the operation the patient's pelvis remains adequate for future labours.

This year we had 41 deliveries following symphysiotomy in the hospital, 28 being new cases. Of these 9 cases had previously undergone section for contracted pelvis. Seven infants were lost, 5 stillbirths and 2 neonatal deaths. One stillbirth was due to concealed accidental haemorrhage during labour. This mother was delivered by section, see Table case No. 45,032. One stillbirth was due to cyanosis and collapse during anaesthesia. One stillbirth the foetal heart was absent after failed medicinal induction. One stillbirth was a breech, (p.m. – asphyxia, should have been extracted earlier). One stillbirth, tumultuous pains following dihydroergotamine for inertia. One neonatal death was due to intracranial haemorrhage, P.O.P. failed forceps. One neonatal death was due to hydrocephalus. We believe that general anaesthesia carries a serious risk to the foetus during trial labour. In these cases we now carry out the operation entirely under local anaesthesia and recommend with enthusiasm the use of Eufocaine to prevent post-operative pain. One case developed persistent stress

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<sup>153</sup> In 1953 the transactions of the Royal Academy 13/12/1953 with visiting speaker Dr Gavin Boyd from Belfast-1954 IJMS 106

incontinence necessitating a repair operation at six months, Case No. 40,624. One other case, No. 46,380, repeat section necessary for persistent inertia”.

**ROTUNDA ANNUAL REPORT: 1<sup>ST</sup> NOVEMBER 1952-31<sup>ST</sup> OCTOBER 1953  
(THOMPSON):**

“Symphysiotomy was carried out on three patients, all primigravidae and in each case was associated with Caesarean section. In all instances the contraction was confined to the mid-pelvis and outlet. Their future obstetrical histories will be observed with interest.

Four patients were delivered following previous symphysiotomy. In two of these cases disproportion was deemed to exist and they were delivered by forceps. The remaining two patients delivered themselves spontaneously and disproportion was not considered to be present in these cases. All four patients had live babies”.

“A small but definite place has been given to symphysiotomy. It has been employed occasionally in conjunction with elective Caesarean section in certain young primigravidae where mid-pelvic and outlet narrowing has been proved. We encountered no case during the year requiring symphysiotomy to effect immediate delivery, though perhaps this is the most important place which the operation holds. It is not considered to be a justifiable procedure in these days of advanced surgery and anaesthesia when employed in the first stage of labour with a view to awaiting spontaneous or forceps delivery later. When used in conjunction with section the operation is simple and non-traumatic and some results from this application have been mentioned (See p. 56). Caesarean section is thought to be preferable for patients over the age of thirty years”.

**1953 ACR The Coombe. Master- JK Feeney:**

“ Experience in Dublin over the past decade has indicated quite clearly that symphysiotomy relieves obstruction in selected cases of disproportion at the brim, in the cavity and at the outlet. With attention to detail, the operation may be easily and safely performed. If these points are accepted, the criticisms which may be directed at the operation are :

- i. Foetal mortality.
- ii. When symphysiotomy is performed early in labour, there is no guarantee that the cervix will dilate.
- iii. The effect upon urinary control.
- iv. The remote influence upon pelvic stability and locomotion.

*Foetal Mortality:* So long as symphysiotomy is performed as an emergency measure, occasional babies will be inevitably lost. In the 80 operations which I have personally performed, there were 3 stillbirths and 3 neonatal deaths. Of these 6 cases, 3 had undergone long labour outside the service of the Hospital, and I had been badly and repeatedly failed by forceps in the country. No operation in these circumstances can avoid foetal loss.

*Failure to dilate:* I have had 4 failures of dilatation, but as experience increases, the cases which are suitable for Caesarean section are more easily chosen.

*Effect upon Urinary Control:* If the arcuate or subpubic ligament is allowed to stretch rather than to tear, the risk of stress incontinence is greatly reduced. Incontinence has not been a troublesome symptom in my cases, but a long-term investigation on the lines suggested by Jeffcoate could with advantage be carried out.

*Influence upon Pelvic Stability and Locomotion:* So far as my follow-up has gone, this need not be feared, but sclerosis of the sacro-iliac joints is an occasional possibility which should be investigated.

A small point in technique : the oozing of blood from the depths of the wound during suturing of the soft tissues may be controlled by the assistant placing his

index and middle fingers, palmar surface upwards, on each side of the urethra, as in the performance of the Bonney test of urinary control.

The real harvest of symphysiotomy is reaped in subsequent deliveries”.

..Number of symphysiotomies 25”

## **1953 Transactions**

### **Gavin Boyd (Belfast) visiting in the 1953 Transactions:**

*“Symphysiotomy might be used as favoured in the National and Coombe Hospitals. I am not satisfied with the results of this treatment, and in particular note that at least one-third of the cases were over the age of 35. I think that in these cases, repeat Caesarean sections could have been done until the end of reproductive life. I am intrigued with the Rotunda practice of performing symphysiotomy at the first caesarean section, and wonder if subsequent vaginal delivery has been obtained”.*

### **DR. MEAGHER**

*“ There is a place for symphysiotomy to take care of disproportion. The commonest indication for Caesarean section is a previous Caesarean section”.*

### **PROFESSOR KEARNEY (CORK)**

*“In Cork we were initially very much against symphysiotomy. Now we do it in the odd case. There is much to be said in its favour. Psychological trauma from loss of the first baby is a problem. It is said that the State Medical Service improves the standard of obstetrics. One speaker said there are 10 specialists outside Belfast. I understand there are 40(or 14?) in Dublin and only 6 outside Dublin”.*

### **PROFESSOR DAVIDSON :**

*"I admit Caesarean section has done a great deal for placenta praevia and accidental haemorrhage. I cannot see that Dr. Barry has proved his case for symphysiotomy. There is too much desire to rush to the operation table".*

**SOLOMONS:**

*"I think the symphysiotomy operation is in danger of being over-rated. I feel that if there were fewer, the successes would be more numerous. If we are not careful we may bring that operation into disrepute. If you carry out symphysiotomy you may well enlarge the brim, but you do not know what will happen down below. It should be limited to a definite outlet contraction. In prematurity and stillbirths the nutritional and social factors are of the greatest importance. Most of our patients are undernourished".*

**BARRY:**

*"In relation to symphysiotomy, we are disappointed that we have not yet succeeded in reducing the foetal mortality to figures that would flatter our egos. However, it must be recollected that these cases are, of course, the troublesome cases of trial of labour, the cases of disproportion where disproportion truly exists, and if they were set amongst all the cases admitted as query disproportion and all the cases admitted for trial labour, the results would look very much more flattering. Also, of course, one cannot hope to attain the same foetal mortality with symphysiotomy following trial of labour as with Caesarean section following trial of labour, because when the trial of labour fails and is ended by section, the foetus is then immediately rescued from its unhappy environment, whereas when symphysiotomy is done labour has to progress to dilatation and delivery and so the foetus has to undergo further stress before labour terminates. However, one should never forget that when the symphysiotomy is performed that the case is suitable, the patient is cured of her contracted pelvis for this and all subsequent labours, an advantage which to my mind outweighs all other disadvantages of the operation in young patients. When one has performed the operation one frequently regrets it while waiting for labour to be terminated. During the puerperium again one frequently regrets it, especially if the patient develops troublesome stress incontinence, or if the disaster of a stillbirth or a neonatal death has occurred. But on a patient's*



*subsequent labour, and on the labour after that, and on the labour after that again, one's confidence in the operation returns and one realises what a boon is being conferred on the patient subjected to this method of managing contracted pelvis if she is at all young. I am whole-heartedly in agreement with Professor Davidson's suggestion that too many operations are being done. I think too many operations of all varieties are being carried out in Dublin today, and I ask you to glance at the figures in this table and to observe that it is not necessary to operate to obtain a low foetal mortality: it is merely necessary to do good midwifery. One of the difficulties of reaching the optimum standard in this city is the overcrowding in hospitals. You may say, of course, that it is simple enough to deal with this problem, not to admit more patients than you can reasonably manage, but this is simply transferring the burden to home delivery, and even more unfavourable in an unsuitable environment for any obstetrical difficulty.....*

*In relation to the performance of Caesarean section in general, I have no doubt that I would like to do some more sections. My difficulty in not performing more sections is that I find it exceedingly difficult to know where to stop. Either the incidence is low and there are some stillbirths, or the incidence becomes extraordinarily high, as can be seen in these figures I am putting before you, without a marked improvement in the total foetal loss. It is well known that obstetrical complications and difficulties are in direct relationship to poverty and poor social class of the mother, and yet it is also well known that in this and most other cities the incidence of Caesarean section is far higher in the better class patients than in the poorer class patients. Until this position changes one must be very wary of the indications for this operation. I am especially slow to extend the scope of the operation when I glance again at the results obtained by the obstetricians of hospitals A and D in the table. I hold that our methods are the right methods, but that we are as yet failing to apply them properly. This failure is largely due to overcrowding and to the difficulty in paying sufficient attention to these cases when the hospital is very full. I am satisfied this problem will largely vanish when Dr. Feeney's new hospital goes into action. A point of special importance in the management of dystocia is the arbitrary*

*carrying out of x-ray pelvimetry on all women 24 hours in labour, unless delivery is certain within the next 3-4 hours”.*

## **FEENEY**

*“Experience in Dublin over the past decade has indicated quite clearly that symphysiotomy relieves obstruction in selected cases of disproportion at the brim, in the cavity and at the outlet. With attention to detail, the operation may be easily and safely performed. If these points are accepted, the criticisms which may be directed at the operation are :*

- i. Foetal mortality.*
- ii. When symphysiotomy is performed early in labour, there is no guarantee that the cervix will dilate.*
- iii. The effect upon urinary control.*
- iv. The remote influence upon pelvic stability and locomotion.*

**Foetal Mortality :** *So long as symphysiotomy is performed as an emergency measure, occasional babies will be inevitably lost. In the 70 operations which I have personally performed, there were 2 stillbirths and 3 neonatal deaths. Of these 5 cases, 3 had undergone long labour outside the service of the hospital, and I had been badly and repeatedly failed by forceps in the country. No operation in these circumstances can avoid foetal loss.*

**Failure to Dilate :** *I had 3 failures of dilatation in my first two years, but as experience increases, the cases which are suitable for Caesarean section are more easily chosen.*

**Effect upon Urinary Control :** *If the arcuate or subpubic ligament is allowed to stretch rather than to tear, the risk of stress incontinence is greatly reduced. Incontinence has not been a troublesome symptom in my cases, but a long-*

*term investigation on the lines suggested by Jeffcoate could with advantage be carried out.*

***Influence upon Pelvic Stability and Locomtion*** : So far as my follow-up has gone, this need not be feared, but sclerosis of the sacro-iliac joints is an occasional possibility which should be investigated.

***A small point in technique*** : The oozing of blood from the depths of the wound during suturing of the soft tissues may be controlled by the assistant placing his index and middle fingers, palmar surface upwards, on each side of the urethra, as in the performance of the Bonney test of urinary control.

*The real harvest of symphysiotomy is reaped in subsequent deliveries”.*

#### **Lourdes Hospital Report for 1953:**

*“symphysiotomy was carried out in 14 cases of disproportion and 14 Caesarean section were performed for disproportion. “*

#### **1954 Lourdes Hospital Report**

29 patients were delivered vaginally after symphysiotomy  
1 patient had a symphysiotomy “on the way out”.

*“ There were no urinary or ambulatory complications experienced in this group. Most of them returned for post–natal examinations, and were experiencing no more aches and pains than the general run of post-natal patients. Local anaesthesia followed by spontaneous delivery where possible, gave the best results.”*

## **1954 Transactions**

**PROFESSOR E.A. GERRARD (Manchester):**

“There is also the question of symphysiotomy to which reference was made at your meeting a year ago. I noted that 46 symphysiotomies were done in your hospitals last year, and also that during that time 20 were successfully delivered by the vaginal route at the National and Coombe in cases where there had been a previous symphysiotomy. One cannot help but feel that this operation might be practised more widely”.

**FEENEY :**

“After 5 years, I am satisfied that symphysiotomy provides a simple, safe and permanent treatment of selected cases of disproportion. Its aim is spontaneous or easy assisted vaginal delivery. It will have defeated its purpose if delivery should prove traumatic. The following cases are generally suitable :-

- a) Cavity/Outlet contraction, in which the head cannot be moved by reasonably strong traction with forceps properly applied.
- b) Cavity/Outlet contraction as verified, by x-ray examination and in which progress ceases after a reasonable trial with the vertex in the pelvis and the cervix about 4 fingers dilated.
- c) As an occasional emergency measure when difficulty is encountered in extracting the head in breech presentation, or as a preliminary to breech extraction in which the fit is tight.
- d) In certain cases of abnormal cephalic presentation.
- e) In those cases of brim contraction, especially of the transverse diameter, but also of the anteroposterior, in which, after a reasonable trial, the head remains high and the cervix about 2-3 fingers dilated, provided the

foetus is in good condition. It is ideal for those cases of brim disproportion, in which the cervix has reached full or nearly full dilatation, but the vertex, bearing caput, merely projects into the pelvis.

f) For dystocia with larger foetus in the multipara.

I say that the operation is safe with this reservation, that it should be performed with attention to detail and in an unhurried manner. If the strong subpubic ligament is not deliberately incised, stress incontinence is not likely to develop. Accidental abduction of the thighs by the assistants during the operation must be avoided at all costs in order to prevent severe soft tissue trauma. Before an opinion can be expressed on such a remote sequelae as sclerosis of the sacro-iliac joints, a long-term follow-up must be carried out. The real harvest of symphysiotomy is reaped in subsequent deliveries”.

**Sister MM Nolan** Obstetrician - Medical Missionary writing of her experience in Nigeria 1954.<sup>154</sup>

*“For years I considered it a dangerous operation, as I believed it easier to control an abdominal infection after a section than an infected bone or joint after symphysiotomy. Now we have sulpha drugs in plenty and at least five kinds of antibiotics on our market. Symphysiotomy seems to answer all our troubles, except when there is ante-partum haemorrhage or osteomalacia or hip deformities; for these we do sections. I do symphysiotomy in multiparae if trial at labour ceases to progress; in multiparae or small pelves, who have had previous dead babies; and in those who have had section. Operation is done at term or just as the start of labour. The patient does not consider that symphysiotomy is much of an operation. I do under local anaesthesia, the patient having been sedated by Pethidine according to the stage of her labour.”*

**ROTUNDA ACR 1954-1955. MASTER – E.W.L. THOMPSON:**

Number of symphysiotomies      2

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<sup>154</sup> 1954 IJMS page 205

“Eight patients who had had a previous symphysiotomy were attended in the hospital during the year. Four of the previous operations had been done in the Rotunda Hospital and four in other hospitals. Of the 8 infants delivered one was stillborn, due to severe foetal distress during labour. This patient had an easy forceps delivery, and the loss of the baby was due to an error in judgement in not effecting delivery earlier.

Three patients required delivery by Caesarean section. One patient who had a previous symphysiotomy in a country hospital had developed a gross spondylolisthesis and was treated on this occasion by “elective” Caesarean section. A second patient developed a brow presentation in labour and section was performed as it was considered unsafe to attempt vaginal manipulations. A third case, in which there was a very severe flat pelvis, was also delivered by section. It is my opinion that this particular case could never have been suitable for symphysiotomy at all. The remaining 4 patients had easy spontaneous or low forceps deliveries, but in one instance the baby was very small and premature and did not present as a disproportion problem at all.

In regard to this operation it continues to be our opinion that there exists a definite but limited place for the use of this procedure. In the Rotunda Hospital the operation is reserved for certain selected cases of android pelvis in very young patients who are likely to have many confinements. It is usually combined in the first instance with Caesarean section”.

**1954 ACR National Maternity Hospital. Master-AP Barry :**

Thirty-three cases are recorded with a gross foetal loss of 4, 1 infant being stillborn and 3 neonatal deaths. The stillbirth was due to a serious error of diagnosis, contracted pelvis having been overlooked until the aftercoming head of a breech was arrested immovably above the pelvic brim, Case No. 50867. One neonatal death was due to pneumonia on the 10<sup>th</sup> day; 1 occurred on the 26<sup>th</sup> day in association with cleft palate and micrognathia and 1 was due to

spina bifida. Thus the operation could in no way be blamed for the loss of any of these infants.

The operation is continuing to yield good results and to render our management of dystocia due to disproportion satisfactory both on the immediate and all subsequent pregnancies. We believe that the results have established beyond any question of doubt that contracted pelvis can now be cured. Some of the cases deserve special attention. Case No. 41226 indicates the reason why symphysiotomy in preference to pubiotomy should always be carried out. In Case No. 43868 we would not have carried out the operation at all except that the first twin had delivered spontaneously and we thought that the second twin would not be very much bigger. This patient arrived in labour with the first head deep in the pelvis and obviously making reasonable progress. The T.C. was only 7.7 cms confirming our view that under 8 cms the operation is not feasible.

Professor Lopez of Montevideo places the limit at 7.5 to 8 cms, but our experience would lead us to place the limit between 8 to 8.5 cms. The European infants, as a general rule, are larger than South American or African infants, also the commonest type of contracted pelvis in these countries would appear to be the male or flattened gynaecoid rather than the anthropoid type, so suitable for symphysiotomy.

...”

#### **1954 –The Coombe ACR, Master- JK Feeney:**

Number of symphysiotomies	19
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“Since December 1949 and up to time of preparation of this Report in the summer of 1955, I have performed exactly 100 symphysiotomies in this Hospital. I had no previous experience of the operation, so the case notes in the Annual Reports indicate the difficulties and complications which I encountered and the mistakes which I made as I learned. One hundred

symphysiotomies have been performed in 20,000 deliveries in the hospital service, i.e. 5 per 1,000. Sixteen per cent of all disproportion cases were treated by symphysiotomy”.

*A summary of the cases was then set out , followed by a detailed description of the technique for carrying out the procedure and a detailed analysis of the authors general remarks and follow up findings. These can be viewed in Appndix II of this Report”*

## **1955 TRANSACTIONS**

### **PROF. A. DUNCAN**

“Once cannot very well come to Dublin and not comment on the operation of symphysiotomy. I am very impressed, and convinced of its value in the failed forceps type of case, but I must confess that I am still unhappy about the prophylactic operation or the symphysiotomy combined with Caesarean section. The sequelae in your experienced hands certainly seems to be minimal. There has been considerable criticism in relation to the incidence of subsequent stress incontinence of urine, but I think we must remember that stress incontinence of minor degrees is very common in women, and that this becomes more clear if patients are asked specifically about the symptom. In this connection you may be interested in the results of a questionnaire study which I recently carried out amongst young multiparous hospital nurses. Of 134 nurses who replied to the questionnaire, 87 or nearly two-thirds stated that they had at one time or other experienced stress incontinence. Of those, 17 had experienced it frequently and 18 at times when the bladder was not even full. In 58 the causative stress was as simple an action as laughing. If we consider that these were young nulliparae I think that we must not criticise too strongly the minor degrees of incontinence displayed for example by some of Dr. Feeney’s followed-up series”.



**PROFESSOR IAN DONALD (GLASGOW)**

"I can see that I must now take my courage in both hands and enter upon the subject of Caesarean section and symphysiotomy. The section rates for the Coombe and the Rotunda are comparable to our own, but one can hardly refrain from commenting upon a 1.13 per cent rate for the National. Now I have a great deal of sympathy for encouraging the use of the vagina in delivery and, following my last encounter with Dr. Barry, I returned to London fully determined to employ symphysiotomy at the first opportunity, although I mentally reserved the indications to those of outlet difficulties late in the second stage. I might add that I am still awaiting what I personally regard as a suitable case. It may be hidebound prejudice which makes one reluctant to inflict a skeletal injury instead of a soft-tissue injury as in Caesarean section. There are three acid tests of the value of symphysiotomy. Firstly, the course of subsequent vaginal deliveries. Here in Dublin a sufficiently large series has been accumulated to vindicate the operation on this score. The next test, namely the incidence of stress incontinence in years to come, we shall have to wait for. The third test I would regard as the patient's own preference were she in full possession of all the medical facts. The obstinate and the unconverted among us may perhaps be misinterpreting our patients' attitude towards being permanently widened, and for all I know they may have less regard for their symphysis pubis than for the muscle of the lower uterine segment which, incidentally, heals very well, but the thought of going through the greater part of labour with one's pelvic girdle partially disrupted in advance would be regarded by many as daunting. I note that more primigravidae with a high head at the start of labour in the National were delivered by symphysiotomy than by Caesarean section. One patient ended up with a section for face presentation, this ultimate "climb-down" being indicated by "contracted pelvis, tonic contraction and failure to convert to a vertex". Surely the attempt at correction, under such circumstances as these, needs more justifying than the section which was eventually performed. I notice, however, that this patient is not likely to get away with a mere section so easily next time, as she had a prophylactic symphysiotomy at the time of her operation. This gospel would not appear to have spread even as far as the

Rotunda, where I note that in 98 cases of contracted pelvis, 51 cases were delivered abdominally”.

**SPAIN:**

“I have been responsible for symphysiotomy, and it has been a very gratifying experience. We did not realise that the shape of the pelvis had just as much to do with labour as the size. We studied these pelvises and the answer was “not Caesarean section” and, with the knowledge which we had gained with radiology, we adopted symphysiotomy. Radiology made all the difference.”

**DAVIDSON:**

“I have been very interested in the modern trend and the question of symphysiotomy v Caesarean section. In Paris many years ago there were two such schools with great rivalry between them. We may see in Dublin a body of symphysiotomists from the South side and a body of Caesarean sectionists, led by Dr. Thompson, from the North side, meeting in the centre to decide the issue.”

**FEENEY:**

“*Symphysiotomy*: In the Report, I have written at length about my experience in 100 cases of symphysiotomy. I commend specially to your consideration and practice its employment in the relief and care of disproportion in the multipara. It is easy to perform and that extra 1.2cm results in an immediate improvement in the pattern of the labour and usually in early spontaneous and atraumatic delivery. The post-operative disability is of the slightest and the obstetrical future is assured.”

**BARRY :**

“I wish to repeat my faith that symphysiotomy is a most useful weapon in the hands of any reasonable obstetrician. I do not deny that from time to time unhappy results arise in relation to stress incontinence and stillbirths, but I know of no obstetric manoeuvre or operation which is not at times associated with such unhappy results. I think that any but the wilfully blind should have no difficulty in bringing himself to realise the value and place of this operation. If you do not believe me, believe Dr. Feeney. It can in no way be compared with lower segment Caesarean section, which simply avoids the issue and is only a temporary escape from the dilemma. If obstetricians would realise that symphysiotomy cures the disproportion for this and all future pregnancies, then they would be able to overcome their reluctance to watching the labour continue after the operation and would not be harassed by such thoughts as wondering would a lady obstetrician allow it to be carried out herself. Surely it will be a sad day for obstetrics when we allow the patient to direct us as to the line of treatment which is best for the case. I would like to say how much I feel we owe to Dr. Alex Spain, who during his Mastership at the National Maternity Hospital had the courage and foresight to reintroduce this procedure to Dublin. But for him we would be without this weapon.”

#### **E.W.L.THOMPSON (ROTUNDA HOSPITAL)**

“Both opening speakers and many others have discussed the use of symphysiotomy. This operation has never become popular in the Rotunda, though I will be the first to admit that in the other two Hospital Reports many very successful instances of its use have been quoted. I have not yet reached the stage when I would have this operation performed upon one of my own family, and being of this mind I still do not feel that it should be freely used in the routine hospital work. I think that the high incidence of stress incontinence is a very big price for the avoidance of a certain number of Caesarean section scars. I must say that I have never looked upon a Caesarean section as being an obstetrical disaster or as a procedure only to be adopted as a last resort. Perhaps I may look upon vaginal delivery following previous section in a much too light-hearted manner. In well over 100 such cases over the past three years

these labours have given rise to very little anxiety, and the foetal and maternal results have been very good.”

In the annual Clinical report this year, **Feeney** analysed 100 cases and commended to all present that the practice of symphysiotomy was a ‘*cure of disproportion in the multipara*’.

*“Since December 1949 and up to the time of preparation of this Report in the summer of 1955, I have performed exactly 100 symphysiotomies in this Hospital. I had no previous experience of the operation, so the case notes in the Annual Reports indicate the difficulties and complications which I encountered and the mistakes which I made as I learned. One hundred symphysiotomies have been performed in 20,000 deliveries in the hospital service, i.e. 5 per 1000. Sixteen percent of all disproportion cases were treated by symphysiotomy.”*

### **Hugo McVey - Rotunda**

wrote an article on the use of a symphysiotomy executed post Caesarean section <sup>155</sup>. The indications for Caesarean section followed by a symphysiotomy were:

- 1) *“Where a trial of labour had failed due to disproportion and the baby was not deliverable vaginally, or if it was, extreme maternal and foetal trauma would be caused.*
- 2) *Where it was considered that if symphysiotomy alone were performed the foetus might be lost due to delay in vaginal delivery.*
- 3) *Where, in a case of disproportion, urgent termination by lower segment section was indicated by other factors, e.g., fulminating toxæmia, marked foetal or maternal distress, mild accidental hæmorrhage, etc.”*

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<sup>155</sup> *The Treatment of Disproportion by Combined Lower Segment Section with Symphysiotomy* IJMS P 299

*In each case a symphysiotomy was then performed in a particular manner. The symphysis was divided down to but not through the arcuate ligament. That technique he said, did not cause ‘ a large symphyseal gap’. He explained that:*

*“ At most, the handle of the scalpel could be inserted between the separate bones and slightly moved laterally to and fro. After separation of the symphysis the parietal peritoneum and abdomen are closed in the usual way.*

*As can be seen from the pelvimetry report in the individual cases, there is practically no increase whatsoever in pelvic diameters and what there is, I am told, is within the limits of mathematical error. This method of minimal separation was adopted as the stretching of the symphysis was not required by the immediate pregnancy. The test of the symphysis would occur at the next confinement during vaginal delivery.”*

*Post operative nursing did not require any form of corset nor were the patient’s movements restricted to any greater extent than would be required as a result of the Caesarean section. ...the relative absence of symphyseal separation allowed for early ambulation with no gynaecological difficulties ensuing.” In subsequent follow up, radiologically there was “practically no increase in pelvic diameters after operation but the increase did occur in subsequent deliveries along the lines of the averages that occurred in what might have been regular symphysiotomies previously recorded by Dr Feeney. There was also no uterine scar rupture in any of the cases studied on subsequent vaginal deliveries.*

McVeigh sets out individual cases studied in writing his paper and concludes that suitable cases for combined lower segment section and symphysiotomy were not frequent but the operation had a “definite place” and was at the time of writing still being performed by Dr Thompson in selected cases. He concluded in the confident proclamation: “ why not unite the age old enemies of section and symphysiotomy, and let them rest in peace together under the one abdominal scar?”

**1955 Lourdes Hospital Report- Connolly:**

3 'on the way out ' symphysiotomy operations.

*“ Experience gained in treating disproportion by this method, indicates the importance of early intervention, local analgesia, and awaiting spontaneous, rather than instrumental delivery. Prophylactic symphysiotomy has not been employed. A transient tendency to stress incontinence lasting for about eight weeks following delivery is not uncommon. In all cases this underwent spontaneous cure. The patient can be told, confidently, that the condition is a temporary one.”*

**1955 ACR, The Coombe. Master- JK Feeney:**

Number of symphysiotomies      15

“In the Report, I have summarized my experience in 114 cases of symphysiotomy. Permit me now to commend specially its employment in the relief and cure of disproportion in the multipara. It is easy to perform and that extra 1-2 cm. results in an immediate improvement in the pattern of the labour and usually in early spontaneous and atraumatic delivery. The postoperative disability is of the slightest and the obstetrical future assured”.

Feeney set out a detailed section on Symphysiotomy which is contained in Appendix II to this Report. He analyses the instances of symphysiotomy performed by him over the previous 6 years, sets out the indications for symphysiotomy, discourages prophylactic procedures and cautions that it should not be performed by junior obstetrical officers

**1956 Lourdes Hospital Report- Connolly:**

Twenty-eight patients had symphysiotomy.

“Apart from one case of elective symphysiotomy and one “on the way out” following Caesarean, all had a full and sometimes unduly prolonged trial of labour. Seven cases had unsuccessful “trial of forceps” before the symphysis was divided. Some of these could undoubtedly have been delivered by forceps at the risk of grave birth trauma. The fact that in some cases the cervix was incompletely dilated was due to disproportion and in these cases progressive dilatation of the cervix had ceased. A few elderly multipara had symphysiotomy performed where, at full dilatation, in spite of good contractions, ruptured membranes, etc., progress ceased. It was felt that the procedure was safer for mother and baby than high forceps or lower segment section. There were no serious complications of the operation and follow up has fully justified its use”.

**1956 –The Coombe ACR, Master- JK Feeney:**

Number of symphysiotomies	32
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In the **1956** Annual Report for the Coombe, Feeney reviewed all 137 cases of symphysiotomy which were carried out over a seven year period:

“I regret that 4 babies were lost in the 32 operations performed in 1956. In 2 of the cases, however, gross congenital deficiency of the diaphragm and gastro-enteritis at 14 days were responsible. One of the other cases should have been treated by Caesarean section. The average duration of the puerperium in all 32 cases was 11.7 days.

In the 1955 Report, I stated my experience of the operation and summarised the cases for 6½ years.

Over the period of 7 years, 137 operations were performed within the hospital and 8 on request elsewhere.

### *Indications*

- a) Cavity/outlet contraction with dystocia, failure of advance or failure of forceps in the second stage of labour - 67
- b) Head engaged in pelvis; contracted cavity/outlet; failure of dilatation - 5
- c) Brim hold-up in multiparae; head not through same; cervix as dilated as it could become under the circumstances; larger foetus than previously - 16
- d) Failure of descent through contracted brim with good pains and cervix admitting 3-4 fingers - 16
- e) Trial of labour; head not through contracted brim; failure of dilatation - 20
- f) Associated with breech presentation - 9
- g) Associated with face or brow and fully or nearly fully dilated cervix - 3
- h) Prophylactic with known contraction or previous Caesarean section - 6 for same
- i) On the "way-out" from Caesarean section - 3

### *Failures*

In 6 cases, symphysiotomy failed to achieve its purpose in so far as the cervix did not dilate or foetal distress developed before dilatation and Caesarean section was done. Three of these patients have had vaginal deliveries since.

### *Foetal Loss*

The gross foetal loss was 15 or 10 per cent. Two stillbirths followed repeated failure of forceps outside the service of the hospital and one occurred after long labour elsewhere with pyrexia, purulent discharge and foetal distress on admission. Two neonatal deaths were caused by congenital deformity and one by gastro-enteritis at 14 days. One baby, distressed at birth, died at 3 days but the autopsy findings were negative. The remaining 8 deaths were associated



with trial of labour, difficult labour and errors of judgment in the selection of the cases.

### *Serious Complications*

In 3 cases, the amount of bleeding caused concern. In one of these cases, soft tissue injury was inflicted by accidental abduction of the legs by the assistants. This patient developed chronic Simmond's disease.

### *Obstetrical Follow-up*

Seventy patients have returned and have had easy vaginal deliveries. A few have been delivered on the district.

### *Suggestions*

In my opinion it is wrong to regard symphysiotomy as an operation which has been introduced in order to supersede Caesarean section. Each operation has its own indications. Although symphysiotomy has its best effect upon the outlet and cavity of the pelvis, the most satisfactory and satisfying indication is provided – peculiarly enough – by brim disproportion in the multipara. This is exemplified by the woman who carries a larger baby than before, or a baby with a bigger head; or, perhaps, the pelvis has become flattened. Labour lasts longer than on previous occasions. The head remains above or impacted in the brim. The cervix becomes as dilated as it can become under the circumstances. Usually, the uterus reacts strongly, unlike in the primigravida. If brow and hydrocephaly are eliminated, straightforward disproportion remains. Symphysiotomy provides an extra 1-2 cm. and delivery takes place with great ease and with no postoperative disability. As I have indicated, failure of forceps delivery in the cavity or at the outlet is an obvious indication. Certain cases of breech presentation provide a most useful indication. With regard to brim disproportion in the primigravida, great care must be exercised in the selection of the case and in the timing of the operation. With x-ray control and with early division of the symphysis, the results should be satisfactory. If the brim is known

to be contracted in minor or medium degree and if the foetal head should remain high after a trial lasting 10-12 hours, the operation should not be postponed. Of course, Caesarean section should be the procedure of choice in some cases. In the operation itself, cut the superior, posterior and anterior pubic ligaments and the cartilage, but spare the subpubic ligament. The posterior ligamentous fibres are stronger than the anatomical text books indicate. When the cartilage is divided, the sub-pubic ligament stretches and sufficient separation is secured. After all, only a little extra room is required if the case has been selected properly. If a difficult forceps or breech delivery should follow symphysiotomy, the whole aim of the operation has been defeated and extensive injury may be inflicted upon the soft parts. In this connection, too, the assistants should not abduct the thighs excessively. Venous bleeding sometimes occurs, but seldom causes anxiety. It is prevented or reduced by falling short of the subpubic ligament in the incision by sponge contact and by the upward pressure of the assistant's fingers in the vagina. An instrument which would exert pressure from below could be devised.

The real harvest of symphysiotomy is reaped in subsequent deliveries. You may well say that unnecessary symphysiotomies are occasionally performed. This is so, but the advantages in the carefully selected case outweigh this disadvantage. I do not like difficult forceps delivery and I abhor difficult breech extraction.

Symphysiotomy or Caesarean section provides a more humane and scientific method of delivery.”

#### **ROTUNDA ACR: 1956 /1957, MASTER –THOMPSON**

Number of symphysiotomies            1

“Some of the less severe cases [of disproportion] could certainly have been treated by symphysiotomy, and probably very successfully. I cannot however, get away from my dislike for the general use of this procedure”.

**1955 ACR, National Maternity Hospital. Master-AP Barry:**

Number of symphysiotomies      33.

“Had two further symphysiotomies been carried out in the mid forceps group the foetal loss would have been eliminated here. For some years we have not felt justified in advocating full pelvic examination under anaesthesia for the primigravida with the unfixed head. The accuracy of radiological pelvimetry is obviously preferable to the risk involved with examination under anaesthesia”.

**1956 Transactions**

**PROFESSOR J. McCLURE BROWNE (LONDON):**

“I find that the Caesarean section rate is somewhat low: 3.7 per cent for the Coombe, 1 per cent for the National and 2.7 per cent for the Rotunda. The forceps rate was a pretty fair one; 8.5 per cent for the Coombe, 10.6 per cent for the National, and 11.9 per cent for the Rotunda. I notice that symphysiotomy is a comparatively unpopular mode of operative delivery at the Rotunda, and I wonder why, because it has seemed to me that the revival of this operation offers prospects of producing a permanent increase in the internal pelvic measurements, and in suitable cases it seems to give an opportunity of avoiding Caesarean section and therefore a trail of *“repeat sections”* or a ruptured uterus without undue hazard for mother and child. I would like to know more about this operation”.

**DAVIDSON :**

“Symphysiotomy seems to be safe enough in the immediate results, but it is too early to say what the ultimate result will be. I would say from reading the Holles

Street Report that they have produced a fine recommendation for symphysiotomy. I have no experience of it, but it would appear that there is something to it. In my time I did pubiotomy, and I feel that if you did symphysiotomy in the same circumstances you would get excellent results. I was interested to see in the report on symphysiotomy no urinary or locomotion difficulty. I wonder is that really true. I am not, of course, suggesting that anyone in Holles Street is overdoing it, but I wonder if that is really true."

**GALLAGHER:**

"For contracted pelvis Dr. Thompson did 64 new sections and in 17 he did not even give a trial of labour. I think he should follow Dr. Barry's method and give every patient a trial of labour and then symphysiotomy. I think the Dublin school of obstetricians owes a great debt to Dr. Spain for bringing in symphysiotomy. Of course, we have no gross cases now, and we have an accurate way of measuring the pelvis. Professor Browne said that he would have sterilized one patient. We are a Catholic country and we do not permit this. Recently in Germany, which is equally Protestant and Catholic, I was speaking to an obstetrician and he told me they usually sterilized a patient after the third Caesarean section without even asking the patient. If you did that here you would be run out of the country in no time. More and more x-ray examinations are being carried out in pregnancy. Is this wise having regard to leukaemia in babies afterwards?"

**THOMPSON (ROTUNDA):**

"Professor McClure Browne raised many points and I will comment only on a few of them. He wondered why symphysiotomy was apparently so unpopular at the Rotunda. This is a comment which is made every year at this Meeting, and by now everyone knows that it is a procedure that I personally dislike. I may be wrong or most likely partly wrong, in my ideas on this subject, but I consider that

it is, apart from anything else, a good policy to have our approach in this matter a contrast to that used in the other two hospitals. We have for many years used Caesarean section freely and we have a very large number of patients who are delivered vaginally following a previous section. It is well known that occasionally a rupture of the uterus can occur in such cases, but it is a risk which to me is greatly exaggerated, particularly in the minds of those who are symphysiotomy enthusiasts.”

**BARRY:**

“Foetal loss is of course higher in this city than in London, but the circumstances are so different. Foetal loss is improving steadily every year under the influence of the maternity hospitals, but childbirth being what it is the loss in a community having four or more children per family must of necessity (until you alter the mode of reproduction) be greater than in communities having one and a half to two children per family. Equal skill, the same methods, equal hospitalisation, equal financial and dietetic facilities will not produce the same result in the larger family as in the small one. The risks to mother and child increase with increasing parity. In the steps to reduce foetal loss I believe that the backing of a very large number of antenatal beds is essential and this should be combined with larger obstetrical staffs, abnormal obstetrics is not a subject for one man, but for the obstetrical team which must include physicians, pathologists, radiologists and surgeons. We are taxed with our low Caesarean section rate. I do not feel that this is something to apologise for; it is a sad thing for obstetrics when people are proud of high section rates. One should feel that to perform a Caesarean is a necessary evil, not a good thing: it is turning away from the natural goal of obstetrics. Let us remember that it is the only obstetrical operation which permanently increases the risk to the mother and child in all future pregnancies, and let us remember that if in the present state of our ignorance (rather than of our knowledge) we find it a necessary way out of difficulty. This should not mean that we should praise ourselves for doing it, but rather apologise when we still find it necessary. Our rate is small indeed

because we have removed the necessity for repeat operations in disproportion. I do not apologise to you for curing my cases of disproportion...

Professor Davidson asked why we did not record our cases of disproportion. He will find 84 cases of trial labour recorded with full details on page 34. If he adds to this the cases of symphysiotomy performed on multigravidae he will have the total number of cases of disproportion and the results. He further asks why we record that cases of symphysiotomy have no locomotor and urinary difficulties on subsequent deliveries. The major objection raised to the operation is that it causes stress incontinence and locomotor difficulties in the future: we are only endeavouring to point out how incorrect these objections are. Do not blame us if the patients do not complain of these imaginary disasters with which the operation has been labelled. He further asked would we give our views on the management of cases of Rhesus incompatibility..."

#### **FEENEY**

"I may be permitted to emphasise a few points about symphysiotomy. In my opinion, it is wrong to regard symphysiotomy as an operation which has been introduced in order to supersede Caesarean section. Each operation has its own indications. Although symphysiotomy has its best effect upon the outlet and cavity of the pelvis, the most satisfactory and satisfying indication is provided – peculiarly enough – by brim disproportion in the multipara. This is exemplified by the woman who carries a larger baby than before, or a baby with a bigger head; or perhaps, the pelvis has become flattened. Labour lasts longer than on previous occasions. The head remains above the brim. The cervix becomes as dilated as it can become under the circumstances. Usually, the uterus reacts strongly, unlike in the primigravida. If brow and hydrocephaly are eliminated, straightforward disproportion remains. Symphysiotomy provides an extra 1.2cm and delivery takes place with great ease and with no postoperative disability. As I have indicated, failure of forceps delivery in the cavity or at the outlet is an obvious indication. Certain cases of breech presentation provide a

most useful indication. With regard to brim disproportion in the primigravida, great care must be exercised in the selection of the case and in the timing of the operation. With x-ray control and with early division of the symphysis, the results should be satisfactory. If the brim is known to be contracted in minor or medium degree and if the foetal head should remain high after a trial lasting 10-12 hours, the operation should not be postponed. Caesarean section should be the procedure of choice in some cases. In the operation itself, cut the superior, posterior and anterior pubic ligaments and the cartilage but spare the sub-pubic ligament. The posterior ligamentous fibres are stronger than the anatomical textbooks indicate. When the cartilage is divided, the sub-pubic ligament stretches and sufficient separation is secured. After all, only a little extra room is required if the case has been selected properly. If a difficult forceps or breech delivery should follow symphysiotomy, the whole aim of the operation has been defeated and extensive injury may be inflicted upon the soft parts. In this connection, too, the assistants should not abduct the thighs excessively. Venous bleeding sometimes occurs, but seldom causes anxiety. It is prevented or reduced by falling short of the sub-pubic ligament in the incision, by sponge contact and by the upward pressure of the assistant's fingers in the vagina. An instrument, which would exert pressure from below, could be devised. If bleeding should occur and if the edges of the wound are retracted for exposure, it is wise to remember that the retraction itself can cause tearing of the pre-pubic and labial tissues. The real harvest of symphysiotomy is reaped in subsequent deliveries. You may well say that unnecessary symphysiotomies are occasionally performed. This is so, but the advantages in the carefully selected case outweigh the disadvantage. I do not like difficult forceps delivery and I abhor difficult breech extraction. Symphysiotomy or Caesarean section provides a more humane and scientific method of delivery".

## **1957 TRANSACTIONS**

### **Prof. W. Kearney (Cork):**

"Symphysiotomy was not considered under a separate heading in the Rotunda Report and I could find only two references to it. On P. 50 it is stated that

symphysiotomy was carried out at the time of performing section in one case. On P. 56 we read that *"the operation continues to be used to a very small extent in the hospital, and only for very selected cases of android pelvis in young patients"*. In contrast the operation was performed on 32 occasions at the Coombe and on 21 cases at Holles Street. At the Erinville Hospital, Cork, we subscribe more to the view expressed by the Master of the Rotunda and confine the operation to relatively young women with mid-cavity and outlet reduction. Nevertheless in 1956 we performed it 4 times in 1,150 intern cases. Surely there must have been several cases during the year that qualified for this operation at the Rotunda. If so, they are not mentioned in the Report. If the operation was not performed except in the one case already quoted, then the Master's limited approval of it is more theoretical than real. I believe that there is a definite place for symphysiotomy in a predominantly Catholic country such as Ireland, where contraception and sterilisation are not countenanced by over 90 per cent of the population. In such circumstances the performance of Caesarean section on a young woman for contracted pelvis is a serious step and should not be lightly undertaken. It means that she may be faced with many repeat sections with increasing risks each time. Symphysiotomy lowers the incidence of section in cases of disproportion. When performed on carefully selected cases it is a safe operation and gives gratifying results. As it is a simple procedure, the technique of which can be readily mastered, there is a real risk of it being performed too often and unnecessarily. It is not an operation for the general practitioner doing domiciliary deliveries. It should be given the same careful consideration as Caesarean section and requires the expert judgement of an experienced obstetrician. I think it was Munro Kerr who said *"let me see a man deliver a breech and I will assess his obstetrical ability"*. To a lesser extent the efficiency of a maternity unit may be judged by its attitude towards breech delivery. The results reported under this section are good in all 3 Hospitals. It would appear that the Rotunda permits a limited number of breeches to be delivered on its District, 31 in 1,013 cases as against 8 in 1,161 for Holles Street and the Coombe together"

#### **C.V. COYLE (NATIONAL MATERNITY HOSPITAL)**



“To Professor Kearney I would say, one of the most satisfactory types of cases for symphysiotomy is the multipara, often the grand multipara, with disproportion at the brim, in strong labour and with signs of obstruction. In such a case, after symphysiotomy, the patient is often delivered before the wound is completely sutured. As to uterine inertia, our criterion is labour lasting over 36 hours”.

#### **ROTUNDA ACR 1957-1958. MASTER - THOMPSON**

Number of symphysiotomies      0

“No cases were treated by symphysiotomy nor was the operation combined with Caesarean section on any occasion. On looking back over the experience gained in the management of contracted pelvis for the past 6 years, I feel that there have been a few cases which would have been better treated through the medium of symphysiotomy. To condemn the operation out of hand is just as unreasonable as to employ it too frequently”.

#### **1957 National Maternity Hospital ACR. Master - FV Coyle.**

Number of symphysiotomies      9

“Symphysiotomy was carried out in 9 cases, without maternal or foetal loss. Details of the cases are set out at some length in the table.

The indications for operation in these cases were :-

- 1) Failure of trial labour in primigravidae when at or near full dilatation.
- 2) As an expedient in obstructed labour in multiparae.

Elective symphysiotomy was not employed. It is felt that trial of labour is still the primary treatment of contracted pelvis or disproportion in the primigravida.”

## 1957 LOURDES REPORT - MASTER – G.A. CONNOLLY

Number of Symphysiotomies

17

“Seventeen patients had symphysiotomy performed with the loss of one foetus. This was a case of hydrocephalus and was diagnosed as such. However, subdural tap failed to drain off any C.S.F. The failure to tap the C.S.F. was because the case was one of internal hydrocephalus and the needle should have traversed brain matter to get to the fluid. In trying to avoid undue trauma to brain matter, the needle was not pushed in sufficiently far, resulting in failure to draw off fluid. Symphysiotomy was done in an effort to obtain a vaginal delivery for this young patient. This, however, did not facilitate delivery and so Caesarean section was performed. The foetus was hydrocephalus with spina bifida and died three days later. Two other cases of disproportion with inertia required section because of failure to progress, following division of the symphysis. They were, obviously, not ideal cases for symphysiotomy, but it was hoped that, as frequently happens, the pains would improve and vaginal delivery be accomplished.

Of the seventeen cases 8 were primigravida. Local analgesia was used, for preference, and in the absence of foetal distress spontaneous delivery was awaited. There were no complication as a result of these operations and the foetal survival was very satisfactory.

..

### *Vaginal Delivery following Previous Symphysiotomy*

During the year 15 patients, who had symphysiotomy in a previous pregnancy, had spontaneous vaginal deliveries. One foetus was stillborn due to prolapse of cord with foetal heart absent before admission. One NND was due to tracheo-oesophageal fistula. None of the complications sometimes ascribed to this operation were seen”

## **1958 TRANSACTIONS**

**(JOINT MEETING WITH THE ROYAL ACADEMY OF MEDICINE IN IRELAND AND THE  
ULSTER OBSTETRICAL & GYNAECOLOGICAL SOCIETY, 14<sup>TH</sup> NOVEMBER 1958)**

**W.R. SLOAN (BELFAST)**

“With regard to the Coombe Hospital and the subject of symphysiotomy. I have no policy on the question of symphysiotomy. It is a spare shot in the bag, which I pull out when I need to. I would like to get some idea as to what place there is for it. It seems to me there are a surprisingly small number in the report of the Rotunda and the National Maternity Hospitals, while in the Coombe six are recorded”.

**DR. STUART (COOMBE):**

“Dr. Sloan raised the question of symphysiotomy : I have not had much experience of it, but it should be done in selected cases. After a symphysiotomy you will have a very easy forceps delivery. It is entirely a matter of experience, and we always get Dr. Feeney to see the patient before doing a symphysiotomy”.

### **Rotunda ACR 1958/59. Master –Thompson**

Number of symphysiotomies      0

“The Seven Year Summary shows ...In a few instances and in very selected cases, symphysiotomy was performed at the time of closure of the abdomen after Caesarean section. There is no doubt whatever that this operation can enlarge the capacity of the pelvis and is probably a most valuable procedure in countries where extreme geographical remoteness from hospital facilities is combined with lack of antenatal care and education, and where there may well exist a severe prejudice in the minds of the patients regarding an abdominal scar. I have found in the Rotunda Hospital that there were very few cases

which I felt were suitable for this operation. In Ireland at the present time patients are never very remote from Hospital care and their awareness of obstetrical matters has greatly improved within the last few years. An interesting point also is that the average age of primigravidae is much higher than in many other countries and a great many of them are unlikely to be involved in multiple sections. Symphysiotomy is certainly never indicated in the management of an “elderly primigravida”, but a good case may be made for it in the event of the very young primigravida who has an android pelvis”.

**1958 ACR, National Maternity Hospital. Master- FV Coyle :**

Number of symphysiotomies        6

“Symphysiotomy was carried out in 6 cases without maternal or foetal loss. Details of these cases are set out in some detail in the table.

In 2 cases (Nos. 63,441 and 63,945) the operation was performed “on the way out” from Caesarean section, the indication for section being disproportion with prolapse of cord in one case and disproportion with foetal distress in the other.

There was one elective symphysiotomy (No. 57,144) in a patient who had lost her 2 previous babies and who had had a previous Caesarean section”.

**1958 LOURDES CLINICAL REPORT -MASTER G.A. CONNOLLY:**

Number of symphysiotomies        21

“There were 21 patients with disproportion treated by symphysiotomy. There was no maternal or foetal loss. The only serious complication was, that in two cases, Caesarean section was required because of failure of the os to fully dilate, due to inertia. Both of these patients have since had spontaneous vaginal delivery. One of them, Reg. No. 621, had an elective symphysiotomy

done 10 days before labour started. X-ray measurements of the brim were as follows : true conjugate 8.6 cms., transverse diameter 12.7 cms. Although requiring Caesarean section for delivery, because of inertia, this patient has since had a normal delivery of a baby weighing 8 lb. 8 oz. One other case had elective symphysiotomy followed by easy vaginal delivery”.

## **1959**

**1959** marked a change in the method of symphysiotomy. Prior to this the procedure was carried out by the ‘open’ method’ but this year saw the trial of the Zarates “Subcutaneous Partial Symphysiotomy”<sup>156</sup>.

### **1959 –The Coombe ACR. Master- JJ Stuart:**

Number of symphysiotomies      13

“Symphysiotomy was carried out in 13 cases without maternal or foetal loss. One symphysiotomy failed, the patient requiring a lower segment section for delivery. The patient’s pelvis was not considered ideal for symphysiotomy but because of her age it was hoped that it might enable her to have a vaginal delivery. Prophylactic symphysiotomy was carried out in 9 cases. In 2 of these a lower segment section had been performed following failed trial of labour in cases of border line disproportion. One was done in a patient who had a previous Caesarean section for toxæmia and whose pelvis on x-ray showed moderate disproportion. Four were done in primigravidae with transverse narrowing of the pelvis, because it was felt that the additional room would benefit them in this and future deliveries. In Case No. 12 the size of the baby was underestimated and it is probable that she would have delivered herself without the aid of the operation.

Four patients had the operation performed during labour. Of these, 3 had easy spontaneous deliveries, and the fourth was delivered by forceps”.

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<sup>156</sup> See earlier in this report for a description of the *Zarate* method of symphysiotomy.

## **1959 LOURDES CLINICAL REPORT. MASTER G.A. CONNOLLY:**

Number of symphysiotomies      17

“Seventeen patients were treated by symphysiotomy without foetal loss. In two cases Caesarean section was later required because of failure to advance. One of these a patient treated by elective symphysiotomy before the onset of labour required section because of inertia. Three patients had elective symphysiotomy performed and two of these had easy vaginal deliveries. Whilst most of these operations have been performed by the usual “open” method, in a few cases, Zarates “Subcutaneous Partial Symphysiotomy” was done with satisfactory results”.

## **1959 Transactions**

### **GALLAGHER:**

“It appears to me that there are many unnecessary sections done for contracted pelvis. Symphysiotomy would give better results, but it must be done at the right time”.

### **DAVIDSON:**

“...but one of the things I want to refer to has already been mentioned – the question of Caesarean section rates in the three hospitals and the fact that Caesarean section in the National is so much less frequent than in either the Rotunda or the Coombe. I was trying to find out why that was, but I was not able to work it out for myself. The only thing I noticed was that Holles Street has a lot of symphysiotomies and of vaginal deliveries. Perhaps Dr. Coyle will explain how he manages to keep the section rate so low apart from his symphysiotomies. I have no doubt that this actually has been going on for some years regarding symphysiotomies. I think the supporters of Caesarean

section will have to admit that there is a place for symphysiotomy. I would like to congratulate Holles Street on the extremely fine table on perinatal mortality...”

**DR. COYLE:**

“We had 30 vaginal deliveries following symphysiotomy. This would occur in a Caesarean section table, so to some extent my predecessors have removed these patients from the Caesarean section table. The incidence of pelvimetries in the National Maternity Hospital can go along with the question of Caesarean section. The pelvimetry rate appears high, but there is a high incidence of post-natal pelvimetry. In a big percentage it is not a case of difficulties at the time of delivery, but the type of patient. A patient with previous Caesarean section must have a pelvimetry before her next labour. We used to have a disproportion table, but it was very difficult to know exactly what to put into it. We attempted to break it down on the basis of the outcome of cases in which the head remains free at term in the primagravida, but it was apparent that many free heads will engage after the patient starts labour. Some were mistaken dates or it was difficult to accurately assess the cases to go in and we decided to omit it. It might be worth reconsidering it again”.

**PROFESSOR CUNNINGHAM:**

“I don’t want to select one as being better than the others, but the format of the report of the National Maternity Hospital in its opening pages is very attractive. I would prefer to see all cases of disproportion, due to contracted pelvis or otherwise, classified under one table, and the treatment of it broken up as to whether delivered by Caesarean section or symphysiotomy”.

**McVEIGH (ROTUNDA):**

“I have no direct questions to ask the Masters, but Dr. Gallagher has amazed me by some of his statements, especially on the question of symphysiotomy, that it should be done early at 38 weeks. The Coombe did 8 symphysiotomies and the National Maternity 6, and in only one of each of those series was it done prophylactically. If a mild degree of disproportion exists at 38 weeks either clinically or radiologically, surely the test is a trial of labour and when trial of labour has failed, then go in with symphysiotomy. Do the Masters approve of prophylactic symphysiotomy as a routine procedure, and is there a case for allowing a patient to go into labour doing a Caesarean section and then doing a symphysiotomy?”

**DR. THOMPSON(ROTUNDA) :**

“I feel there is very little place for prophylactic symphysiotomy. He says the patient should have a trial of labour. If you think she is going to have a very difficult delivery and if you think you can make it much easier by doing a symphysiotomy, I think during labour is the time to do the symphysiotomy. I don't think any of us are experienced enough to say that a patient will want a symphysiotomy, that she won't deliver without it and that she will deliver with it. I much prefer to wait till she goes into labour”.

**DR. SMITH:**

“I have a question for Dr. Coyle. Does he feel the indications for symphysiotomy are less frequent now than they were years ago? I feel that has changed in the nature of the population and that possibly 6 cases this year might be equivalent to 30 cases five or ten years ago”.

**DR. COYLE:**



“In regard to symphysiotomy, I don’t think the indications for the operation have changed considerably. I think it is just a chance that they were so few this year. There may be more next year. With regard to Dr. McVeigh’s question about prophylactic symphysiotomy, we have done prophylactic symphysiotomy this year and it proved very satisfactory. In most cases I think a distinction must be made between early symphysiotomy of a patient in labour and one where labour goes on too long, as foetal loss may arise then.”

**PROFESSOR R.J. KELLAR: (DEPARTMENT OF OBSTETRICS, EDINBURGH UNIVERSITY):**

“I think I have not much to say on any particular subject brought up. I saw symphysiotomy done in Durban with great success”.

**1959 ACR, National Maternity Hospital. Master-FV Coyle.**

Number of symphysiotomies      25

“Symphysiotomy was carried out in 25 cases, an incidence of 0.6% of all deliveries over 28 weeks’ maturity. These cases are described in some detail in the table.

There were 3 neonatal deaths. Two of these neonatal deaths occurred in patients delivered by Caesarean section, symphysiotomy being done following delivery. Both infants died from resorption atelectasis. The third neonatal death was due to intracranial haemorrhage. In this case (Case No. 66,482) trial of labour had lasted 38 hours when symphysiotomy was performed. The infant was delivered spontaneously 1 hour 45 minutes later. In view of the fact that this patient had an android flat pelvis with a true conjugate diameter of 8.8 cms., it would appear that earlier recourse to symphysiotomy would have saved the infant.

Symphysiotomy was carried out in 7 patients following delivery by Caesarean section; the indication for abdominal delivery being foetal distress in 4 and malpresentation in 3 cases. The rationale of treatment in these cases was (1) there was an indication for immediate delivery, (2) the pelvic capacity was such that repeat Caesarean section would have appeared inevitable in the future.

The operation was performed as an elective procedure in 2 cases. In one case (No. 64,340) the patient had previously been delivered outside the service by Caesarean section for disproportion. In the other case the indication for operation was “unengaged” breech presentation at 41 weeks in a primigravida with an unfavourable pelvis. Both deliveries were uneventful.

In one case (Case No. 66,328) Caesarean section was performed 9 hours following symphysiotomy, the indication being foetal distress at 2 fingers dilatation of the cervix”.

## **1960 TRANSACTIONS**

**PROFESSOR H.C. McLAREN (DEPARTMENT OF OBSTETRICS & GYNAECOLOGY,  
UNIVERSITY OF BIRMINGHAM):**

*“Vaginal Deliveries following previous Caesarean section: The 7 year results from the Rotunda are in line with the National and the Coombe; vaginal delivery after section is now commonplace. Moreover, the large numbers of successful deliveries (460) under Dr. Edward Thompson’s direction at the Rotunda carried a negligible accident rate and this does great credit to his team. I beg that he publish these figures in the literature without delay.*

I am most grateful for the Rotunda figures for they help me with my preaching in Birmingham on the general theme of removing the child from danger without undue delay. *“Why was this child at risk?” “Why this delay in establishing respiration, etc?”*

Perhaps next year we may see Dublin join us in a slight rise from your 3 per cent Caesarean section rate to our 5 per cent. The figures do not matter so much as the obstetrical approach to the baby at risk”.

*“Caesarean sections for young patients:* And now one final complaint which really has a philosophical background: young Bridie O’Rourke, aged 18, is exhausted after 24 hours of labour; her baby has signs of distress. In 1960 should we not think of her along similar lines as we should if she came from the Fertility Clinic aged 38? Must we write down on the record *“Reason for delay in section – to avoid a section in a young mother”*? For 1960 it would be of greater interest to collect patients in this younger group where we all tend to carry our conservative methods of obstetrics perhaps a little further than in the older patient? (And we must list among our failures the meconium-bespattered baby which after prolonged resuscitation commences to establish respiration). You will gather that I think nothing of the obstetrician who passes over the occasional stillbirth by saying *“She is young, she will recover and come back next year!”* The young mother and her husband suffer just as much at 18 as the couple who are nearing their 40’s”.

#### **1960 ACR, The Coombe. Master- JJ Stuart:**

Number of symphysiotomies                      17.

“Symphysiotomy was carried out in 17 cases during the year. There was no maternal death. One patient, because of failure to advance and the development of foetal distress, was treated by Caesarean section. There was one neonatal death from pulmonary syndrome of the newborn. Prophylactic symphysiotomy was carried out in 4 cases. The first was carried out in a virtual primigravida with a flat pelvis and a breech presentation. The second was done in a primigravida with a generally contracted pelvis. The third was performed also in a primigravida with a contracted pelvis, and membranes ruptured before the onset of labour. The fourth was done in a primigravida with a small asymmetrical gynaecoid pelvis.

Of the 13 cases performed during labour, one patient had the operation performed following 2 previous Caesarean sections for disproportion, and two following one previous Caesarean section.

In the series there were eight spontaneous vertex deliveries, seven forceps deliveries and one breech delivery.

#### **1960 & 1961 Lourdes Hospital Report. Master- Connolly.**

Number of symphysiotomies      48

48 cases of symphysiotomy performed at Our Lady of Lourdes Hospital in those 2 years. It was reported that:

*“ The indication for performing symphysiotomy was mainly failure to advance in labour deemed to be disproportion... 4 cases of brow presentation were treated by way of symphysiotomy being the safest way out of the difficulty.*

The vacuum extractor was used in conjunction with symphysiotomy in 14 of the cases. By now the Zarates method was the preferred method, having been used 40 of the 48 cases. By 1963, the Zarates Method was used in all cases in Our Lady of Lourdes Hospital.

#### **1961 ACR, National Maternity Hospital. Master-FV Coyle.**

Number of symphysiotomies      12

Symphysiotomy was carried out in twelve cases, an incidence of 0.2% of all deliveries over 28 weeks' maturity. There was no maternal mortality or puerperal pyrexia associated with the operation, but there was perinatal loss of one.

Symphysiotomy was performed as an elective procedure before the onset of labour in three patients previously delivered by Caesarean section for disproportion. In one of these cases (Case No. 60444) repeat Caesarean section was necessary for foetal distress. The other two patients were successfully delivered vaginally of infants weighing 7 lb. 14 oz. and 9 lb. 5 oz.

In four cases symphysiotomy was performed “on the way out” following Caesarean section.

The perinatal death occurred 45 hours after delivery in an infant weighing 8 lb. 14 oz. Postmortem revealed intracranial haemorrhage.

#### **1961 Rotunda ACR. Master- ADH Browne.**

Number of symphysiotomies      1

“Symphysiotomy was done on one occasion on a primigravid patient. The liquor amnii became infected. After 34 hours labour maternal and foetal distress were evident, a vaginal examination revealed a deep transverse arrest with reduction of the lateral diameters in the pelvic cavity and slight reduction of the conjugate vera. It was felt that symphysiotomy would provide the increased capacity required to effect vaginal delivery, and the infected liquor constituted a contra-indication to Caesarean section. The operation was performed without difficulty straight away and the head was delivered cautiously by Kielland’s forceps following rotation to occipito anterior. The puerperium was uneventful, although later a small sinus appeared in the incision. This subsided spontaneously.

Two patients who had a symphysiotomy previously were delivered by Caesarean section, and in each case subsequent to symphysiotomy two sections had preceded the present operation.

Symphysiotomy is advocated in order to increase the pelvic capacity thus permitting vaginal delivery at that time, and it is suggested that the fibrous union at the site of symphysiotomy will expand sufficiently in future labours to permit vaginal deliveries on subsequent occasions. Presumably it is felt that this course is safer than performing Caesarean section on the initial occasion and repeating the operation when necessary in the future. A preliminary study of Multiple Repeat Caesarean Sections from the Rotunda Hospital records by Dr. Terence Hynes suggests that multiple repeat section in fact constitutes a very small degree of danger to the patient. Out of the 115 cases who had already undergone at least three previous Caesarean sections there was no rupture of the uterus, no maternal mortality and minimal foetal loss”.

**1961 ACR, The Coombe. Master- JJ Stuart:**

Number of symphysiotomies	12
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*“Symphysiotomy:-*Symphysiotomy was carried out in 12 cases during the year, in 8 cases during labour and in the remaining 4 as a prophylactic measure. There was no maternal nor foetal death. In 7 cases it was performed on primigravidae and in the remaining 5 on multigravidae. One patient had a previous Caesarean Section for disproportion. There were 4 spontaneous deliveries. Three infants were delivered by means of the vacuum extractor, 3 by forceps, and there were 2 breech deliveries. The vacuum extractor I consider a safer method of delivery than forceps, especially where rotation is required. The lesser bulk of the instrument minimizes the strain on the attachments of the anterior vaginal wall.

I have found the principal indications for Symphysiotomy to be :-

- 1) A young primigravidae with minor or moderate disproportion. If a trial of labour fails and Caesarean Section is resorted to, in all probability future deliveries will have to be by Caesarean Section.

- 2) Disproportion in the multipara with a slightly larger baby or secondary contraction of the pelvis.
- 3) In cases where an attempt at forceps delivery has failed due to contraction of the mid-plane or pelvic outlet.
- 4) In breech presentation where vaginal delivery has been decided on but where difficulty may be expected due to a moderately contracted pelvis. In these cases I find a prophylactic Symphysiotomy 2 weeks before the expected date of delivery very satisfactory.

*Vaginal Delivery following previous Symphysiotomy :-*

There were 20 patients who had vaginal deliveries following previous Symphysiotomies. There was no maternal death. One infant was macerated at birth, the cause of its death being unknown.

None of these women on careful questioning showed any of the disabilities so commonly attributed to this operation. None of them had any abnormality of gait or stress incontinence.”

## **1962 TRANSACTIONS**

### **GALLAGHER**

“ I think if we are going to state a policy with regard to Caesarean Section in Dublin it should be to keep down the number of Sections as far as possible. One way of achieving that would be for the three Masters to select 30 cases a year each and do elective symphysiotomies on them. Dr. Browne was very much opposed to using oxytocic drugs for prolonged labour; that is against the current opinion here and elsewhere... I am glad to see that Dr. Browne is thinking of giving up pelvic assessment. In this connection I notice that 2 patients were passed as suitable for delivery and trial of labour and both had hydrocephalus. That gives one a very poor opinion of pelvic assessment as a method of assessing whether the head will go through the brim”.

**DR. KAMHAWI :**

“There are two points I would raise in connection with the National Maternity Hospital Report. The first is symphysiotomy. 12 symphysiotomies were done in that hospital; 4 were done on patients who went home from the hospital so they were not put to the test of labour. Of the remaining 8, 2 had to have lower segment operation done; a third had pelvic forceps application with a baby which died of intracranial haemorrhage. So there were 3 cases of failure in these symphysiotomies”.

**DR. A. BROWNE:**

“It is interesting that the longer man is Master of a Maternity Hospital the more he gets worried about sections and repeat sections, and the more he tries to find a way of avoiding them. Symphysiotomy seems to be the answer and I quite agree that elective symphysiotomy must surely be a correct indication rather than symphysiotomy done during labour. I don't think Dr. Gallagher is quite correct as regards my attitude towards oxytocic drip – I think there is a place for it”.

**1962 ACR, National Maternity Hospital. Master-FV Coyle :**

Symphysiotomy was carried out in 19 patients, an incidence of 0.3% of all deliveries over 28 weeks' maturity. There was no maternal death or puerperal pyrexia associated with the operation. There was no perinatal loss, but one infant died at 8 days, death occurring following operation for meningocele.

Ten patients had symphysiotomy during labour, two having been delivered previously by Caesarean section. One case was subsequently delivered by Caesarean section, the indication being inco-ordinate uterine action and foetal distress.



Six patients had elective symphysiotomy before the onset of labour; the indication in 4 cases was a history of previous dystocia and in 2 cases previous Caesarean section for disproportion. One of the latter cases (Case No. 73094) was again delivered by Caesarean section and at operation was found to have an incomplete rupture which was successfully repaired.

In the remaining 3 cases, symphysiotomy was performed “on the way out” after Caesarean section in young patients where the pelvis was known to be contracted.

Of the 14 cases delivered vaginally, 6 had spontaneous deliveries, 4 were delivered by forceps and 4 by vacuum extractor. The latter method of delivery would appear to be very suitable in cases where operative delivery is indicated following symphysiotomy, as in many such cases rotation of the head fails to occur and attempts at rotation by hand or forceps in the traditional manner are potentially dangerous to the maternal soft tissues”.

#### **1962 ROTUNDA ACR . MASTER ADH BROWNE:**

Number of symphysiotomies        3

“Symphysiotomy was used on 3 occasions for management of obstructed labour due to midpelvic or outlet contraction. In each case the obstructed labour was overcome and the pelvic capacity increased sufficiently to enable forceps delivery without much difficulty. Two of the patients however, have had considerable disability from stress incontinence, and this coupled with the rather prolonged convalescence necessary following the operation make it difficult for me to accept it for use in any but occasionally selected cases where a funnel-shaped pelvis leads to obstructed labour at the plane of least pelvic dimensions”.

#### **1963**

#### **1963 ROTUNDA ACR, MASTER ADH BROWNE.**

Number of symphysiotomies        3

“Unfortunately disproportion cannot be regarded as a single entity, because the occurrence of a free head at or immediately before full gestation is commonly associated with the occurrence of postmaturity before delivery is achieved. Thus disproportion, postmaturity, and dystocia form a natural sequence of events militating against the welfare of the foetus. It might be postulated that failure in engagement of the foetal head at or before term leads to failure in Ferguson’s reflex which is important in the initiation of the onset of labour. Thus symphysiotomy performed before the onset of labour might be expected to be a highly successful procedure and in fact such an elective operation would seem the ideal place for symphysiotomy. If, however, for any reason one hesitates to do symphysiotomy one might consider induction of labour at a selected period before full maturity to offer the best prospects of success. The dangers of the method, however, offset its potential advantages. One is therefore left with the impression that an expectant attitude should be adopted in the hopes of a spontaneous onset of labour, but if this fails, a positive attitude to the performance of an elective Caesarean section during the 41<sup>st</sup> week of gestation has everything to recommend it. The more one considers the matter, the less do elaborate clinical or radiological investigations seem to matter in a well equipped maternity unit, although they have an obvious and important place in selection of cases for domiciliary delivery outside such a unit”.

**1963 ACR, National Maternity Hospital. Master- Kieran O’Driscoll :**

Number of symphysiotomies        12.

“Two mothers suffered vesico-vaginal fistulae but recovered complete continence on simple management. One of these had had an attempt at forceps delivery at 3 fingers dilatation after 3 days in labour, before admission. A third patient who suffered damage to the urethra had persistent stress incontinence of extreme degree. This was not improved by a subsequent Kelly-type suburethral repair and will need plastic surgery. There was no case of orthopaedic disability. A summary of the cases is set out below.

There were 22 vaginal deliveries in patients who had a symphysiotomy in a previous pregnancy. There was no maternal disability. There was one perinatal death. In this case intrauterine death occurred at 39 weeks, some days before the onset of labour. There was no clinical reason for this and post-mortem examination revealed maceration only”.

**1963 ACR, The Coombe. Master- JJ Stuart:**

Number of symphysiotomies                      5

“Symphysiotomy was carried out in 5 cases during the year, 4 times on primigravidae and once on a multiparae. The operation was performed on 3 patients during labour, and was followed by easy delivery. One patient had a Caesarean section, because of a breech presentation and a small pelvis. Symphysiotomy was done following the section. One patient had the operation 2 weeks before term. She had an easy low forceps delivery. There was one stillbirth which occurred in a case of failed forceps. This was a patient who had a previous spontaneous delivery of a baby weighing 7 lb. 2 oz. This infant weighed 9 lb. 6 oz.

*Vaginal Delivery following previous Symphysiotomy :-*

Sixteen patients were delivered during the year following previous symphysiotomy. All patients delivered themselves spontaneously. There was one stillbirth. The infant weighed 2 lb. 1 oz. and was macerated”.

**1962-1963 LOURDES REPORT-- G.A. CONNOLLY**

Number of symphysiotomies                      40

“ Forty patients were treated by symphysiotomy, an incidence of 1.3%. There was no foetal or maternal death. In 36 patients, vaginal delivery was successfully accomplished, but 4 others need Caesarean section because of failure to advance or foetal distress. Local analgesia was used in 21 cases and general anaesthetic in 19. Zarate’s “Subcutaneous Partial Symphysiotomy” was the method used in all cases. One case developed stress incontinence and was successfully treated by suburethral repair. The more frequent use of oxytocin drip and the vacuum extractor will, undoubtedly, help to reduce the need for symphysiotomy.

### **1963 TRANSACTIONS**

#### **W.G. MCGREGOR (POST-GRADUATE MEDICAL SCHOOL, LONDON):**

“ I am not clear about the incidence of stress incontinence or vaginal fistulae after this operation. I think that abdominal delivery or vaginal delivery is simpler for the patient. In the Rotunda Report, page 33, I think there were a couple of patients who developed stress incontinence afterwards. I wonder why, particularly in the multipara, more use is not made of induction of labour at 38-39 weeks in these circumstances, and induction perhaps a bit later in the primigravida – about 40 weeks. If you are in doubt about maturity don’t do it but if you are sure of maturity I think it is a useful procedure”.

#### **1964 Rotunda Annual Clinical report- Professor A. D. H. Browne:**

Number of symphysiotomies	4
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*“...None of these cases suffered from orthopaedic or urinary complications . The Zarate technique was used on all occasions. Symphysiotomy requires a high degree of clinical judgement, and can be attended with much anxiety. Its place is limited but definite. Its best use in my opinion is in the case where advance ceases due to disproportion with the greatest diameter of the head*

*situated approximately at the level of the ischial spines, and where there is clinical evidence of mid pelvic and outlet contraction. We probably have tended to use the operation too late in labour, and with increasing experience it has been used earlier to better effect."*

**1964 ACR, National Maternity Hospital Master- O'Driscoll :**

Number of symphysiotomies 5

"The oldest mother was aged 24 years. Four vaginal deliveries were affected at the price of one perinatal death. Two had been delivered previously by L.S.C.S. following trial of labour. After elective symphysiotomy on this occasion trial of labour again failed in one case and an unsuspected incomplete rupture of the lower segment scar was found at repeat section. This was repaired. There were no other complications..."

**1965 ACR, The Coombe. Master- William Gavin:**

Number of symphysiotomies 4

" This operation was carried out four times during the year without maternal or foetal loss. The history of each case and the main features of their pelvises are set out in the table. All four patients were delivered vaginally. One patient was only 15 years of age. Two were 23 and the fourth was 30. All four had diminished transverse diameter of the pelvis. There were no residual complications as a result of the operation. Early ambulation was encouraged and the patients were discharged home less than two weeks after delivery. In 3 patients symphysiotomy was carried out before labour commenced and in the other case the patient was in labour over 24 hours when the operation was performed. In the latter case it was thought that the patient might deliver vaginally without symphysiotomy and therefore a trial of labour was given. In cases of breech presentation in primigravida with borderline pelvis,

symphysiotomy performed electively prior to the onset of labour or early in labour ensures an easy breech delivery. Elective symphysiotomy in cases of moderate disproportion may by allowing the presenting part to fit into the pelvis, prevent these patients from the added complication of postmaturity.

It is an ideal operation for cases of moderate disproportion, especially in young primigravidae, as it overcomes the necessity for repeat Caesarean Section by giving a permanent cure for the disproportion”.

#### **1964 - 1965 Lourdes Hospital Report-Connolly:**

Number of symphysiotomies      22

“Twenty-two patients were treated by symphysiotomy, an incidence of 0.55%. The results were poor, as two foetal deaths occurred, one a stillbirth and the other a neonatal death. The stillbirth occurred in a primigravid patient, with disproportion, who had been on an oxytocic drip, for 24 hours. The foetal heart disappeared an hour after symphysiotomy when the cervix was almost fully dilated. It was regretted that Caesarean section had not been done rather than symphysiotomy. The neonatal death was in a patient having her thirteenth baby. Vacuum extraction had failed, so symphysiotomy was performed, followed by spontaneous delivery of an asphyxiated baby five minutes later. A general anaesthetic at the time of operation probably contributed to the foetal death.

The oxytocic drip was used much more frequently in the two years under review, than in previous years. There is no doubt that it is a great asset in shortening labour, and it has reduced the number of patients requiring symphysiotomy for borderline disproportion”.

## 1965/66 Transactions

**Barry** in 1965<sup>157</sup> delivered a paper to the obstetrics section of the Royal Academy of Medicine in Ireland on the management of breech presentations:

*“It would seem reasonable to conclude that the vast majority of breech presentations can be safely handled per vias naturales and that this complication does not call for a Caesarean section rate of more than 4 or 5 per cent. Symphysiotomy is a most useful procedure in the young primigravida with contracted pelvis and breech presentation and is best performed as an elective procedure. In every breech labour steady progress is to be encouraged and there should be ready resort to the Pitocin drip. One of the main indications for Caesarean section should be a failure of reasonable progress in the first stage of labour. In the management of the second stage of labour every effort should be made to deliver the child before distress arises, and again although undue haste is dangerous, steady progress must still always be sought. The basis for success is to handle the case just as you would a vertex presentation, deliver the baby as soon as any suspicion of foetal distress arises, or as soon as it becomes obvious that progress is not reasonable. If the breech is deeply engaged at the start of labour and descends through the pelvis rapidly the prognosis for safe vaginal delivery is excellent.*

*...”*

### **CONNOLLY:**

“Dr. Gavins has several tables and I think we should have about half a dozen tables. I notice he is doing a few symphysiotomies on which I congratulate him, but if he delivers symphysiotomies with a forceps I think he will run into trouble. I think the vacuum extractor is much superior. It does not seem to be much used in Dublin which is a pity. Dr. Alan Browne’s figure for its use has fallen from 100 in 1962 to 20 in 1965. I congratulate him on the fact that when he became Master seven years ago the perinatal mortality was over 50, and it is now down to 37. Dr. O’Driscoll thinks that disproportion is very uncommon in

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<sup>157</sup> Breech Delivery by Arthur P Barry IJMS may 1965 p 231

this country. I feel it is more common than he suggests. He says he had about 4 cases and 4 other doubtful cases. I notice he did Caesarean section for 8 breech deliveries. I don't know why he did Caesarean section in 8 cases of primary breech delivery and I would like him to comment on that".

**PROFESSOR HUNTINGFORD (PROFESSOR OF OBSTETRICS AND GYNAECOLOGY IN THE UNIVERSITY OF LONDON AT ST MARY'S HOSPITAL MEDICAL SCHOOL LONDON):**

"You brought up the question of disproportion. Are you taking issue with Dr. O'Driscoll about its incidence? I could not argue on this but we have a certain Irish population in Paddington and I would think disproportion amongst the Irish emigrants in London was quite high. But we do see a much higher proportion of primigravidae than are seen in the Dublin hospitals. We have 60% primigravidae. I wonder if your remark stems from the parity, or are you talking of more heavy babies?"

**CONNOLLY:**

"I am talking about both".

**PROFESSOR E. O'DWYER:**

"Disproportion is something which is disappearing because of the improved circumstances of the people. Perhaps Professor Huntingford has more Connemara people in Paddington than you have here! When I went to the West of Ireland 8 years ago disproportion was much more common than it is now, and those in whom we got it were not primigravidae but people with 6 or 7 children."

**DR. MACDONALD:**

"I wonder in 1966 had the National Maternity Hospital *"sold"* symphysiotomy to the Rotunda. In 1965 there were 2 symphysiotomies at the National, 4 at the Coombe and 6 at the Rotunda. In 1955 there were 15 in the Coombe, 33 at the National Maternity Hospital and none at the Rotunda. I am worried by Dr. Alan



Browne's comment that this operation is worthy of more extended use. I feel with 12 symphysiotomies in 13,000 deliveries we may have reached the extended use to which he refers and that the incidence of 1 in 1,000 might be a compromise which would leave the three hospitals happy".

**BROWNE:**

"Dr. MacDonald referred to our symphysiotomies. I am a convert over this. Some years ago I would not have done a symphysiotomy but I have become impressed by it and I feel every obstetrician should at least know how to do it. One circumstance in which it is life-saving is when the head of a breech is stuck and you cannot get it out. One baby was undoubtedly saved by ability to do a symphysiotomy. It is a technique worthy of study by everybody but I did say it is only suitable in selected cases and in selected circumstances such as women of 19 or 20 with many babies to come. It is better to have a symphysiotomy scar than a section scar. It is a great feeling to do a symphysiotomy and convert an impossible situation into one that is straightforward and easy. The women themselves seem to be quite happy after it".

**DR. K. O'DRISCOLL:**

"The question of disproportion was raised by many people. The most objective assessment I could make of disproportion is already written down. One woman under 30 was operated for disproportion in Holles Street last year. She was 26 and had symphysiotomy. There was no Caesarean section performed on a primigravida for disproportion last year in Holles Street. There were 4 traumatic intracranial haemorrhages – these were associated with breech delivery... Disproportion is a mote in the eye of the obstetrician – it does not exist...

...

Dr. MacDonald mentioned symphysiotomy. I have put myself in a position in which I cannot advocate symphysiotomy. I have had a fairly large experience of it. The very first symphysiotomy done in Dublin was in 1943. There is no

question in my mind now but that symphysiotomy in the majority of cases was not in fact being done for disproportion. To me the idea of doing an emergency symphysiotomy for the delivery is open to very serious criticism indeed”.

**Rotunda ACR 1965, ADH Browne:**

Number of symphysiotomies        6

“There were 6 cases of symphysiotomy in 1965, in one case (No. 69860) the details of which are noted in the comment on Neonatal Deaths under Disproportion above) the baby was lost. The method of management was reasonable, and the loss of the baby was due to asphyxia due to cord strangulation. In one case (No. 72811) symphysiotomy was attempted in a primipara age 37. After operation it was decided that the outlet was still too small to permit safe delivery and section was immediately undertaken. Case No. 70517 was an outstanding example of the benefits derived from emergency symphysiotomy in the management of breech presentation, and without this operation (so admirably described by O’Sullivan) the baby would certainly not have survived. The remaining cases were uneventful, and uniformly successful. In no case did urinary or orthopaedic disability arise following the operation”.

**1965 National Maternity Hospital ACR. Master- O’Driscoll :**

Number of symphysiotomies        2

The number of symphysiotomies was the lowest since the procedure was revived twenty-five years ago, and it is a tragic irony that the only mother who died within the Hospital during the year was one of these cases. Any association between the operation and the cause of death seems unlikely but this is a matter of opinion. In the immediate sense, both operations were very successful and the second case clearly illustrates the benefit it can confer on a young woman. Significant degrees of contracted pelvis are uncommon in Ireland since only a proportion of these are of a type considered suitable for this

treatment the scope for the operation is limited. It is further limited by considerations of age being hardly entertained after 30 years”.

## **1966 TRANSACTIONS**

### **1966**

**IAN DONALD ( REGIUS PROFESSOR OF MIDWIFERY, UNIVERSITY OF GLASGOW):**

“The Caesarean section rates in Dublin are clearly very much lower than ours in Glasgow, namely 4 per cent of the national, 5.9 per cent of the Coombe and 6.2 per cent of the Rotunda. Ours is 8 per cent. Ten years ago the figure at the National was 1.13 per cent and I recall that at the discussion Dr. Gallagher then complained that with the extended use of Caesarean section the Masters were becoming like County Surgeons, I rather gathered a term of abuse”.

...

“After the last meeting in 1955 I came away from Dublin more impressed with symphysiotomy than I would be today. It seems to be dying a natural death. I could find none mentioned in the Coombe Report, only 5 at the National as compared with 33 cases ten years ago, and 4 at the Rotunda, one of whom still had to be delivered by Caesarean section. Two of the Holles Street cases had been delivered previously by Caesarean section and elective symphysiotomy was carried out and a trial of labour again failed. In one of the cases the uterus was ruptured. I can’t help feeling that this is attempting to secure delivery per vaginam at too high a price. I am still, however, convinced of the value of symphysiotomy in underdeveloped communities such as in East Africa where patients disappear into the bush for their next baby after a Caesarean section and where at Makerere, which I visited last summer, 25 per cent of uterine ruptures are in previous Caesarean section scars”.

**CONNOLLY :**

“As I seem to have got a reputation for being an addict of symphysiotomy, I would like to say a few words on this subject. I think the use of the drip and of the vacuum extractor is cutting down the need for symphysiotomy. We deliver around 2,000 babies over 28 weeks in Drogheda and we have almost completely gone over to the vacuum extractor. If we cannot deliver with the vacuum extractor and drip we divide the symphysis but my figures for symphysiotomy have dropped considerably.”

**O'DRISCOLL:**

“Symphysiotomy I believe is dying a natural death; at the same time I believe it has a place. We did 5 cases all under 25 years of age. I also have no doubt there is a place for it in less developed communities but to continue to do symphysiotomies in this community is to create a wrong impression”.

**1966 National Maternity Hospital ACR, Master- O'Driscoll :**

Number of symphysiotomies      1

“The incidence of symphysiotomy has fallen to a low level. This is not the result of a prejudice against the operation but to the recognition that significant degrees of contracted pelvis are rare in this population. This in turn is in large measure due to the adoption of a positive approach to the subject of prolonged labour, which condition has shown a corresponding decline. There has been no increase in the number of caesarean sections for contracted pelvis and this subject is developed in the chapter on Disproportion.”

**1966 –The Coombe ACR, Master- William Gavin:**

Number of symphysiotomies      4

“ Symphysiotomy was carried out 4 times during the year without maternal or foetal loss. All patients were primigravidae and were delivered vaginally: they were all in their early 20's. In all cases the transverse pelvic diameter was diminished. In 2 cases of Symphysiotomy was performed electively before labour commenced. In the other 2 progress of labour was delayed and Symphysiotomy resulted in rapid and easy conclusion to the labour. In both the latter cases it was thought that the patients might deliver vaginally without Symphysiotomy and therefore trial of labour was allowed.

In carefully selected cases Symphysiotomy is an ideal operation where there is moderate disproportion especially in young primigravidae, as it overcomes the necessity for repeat Caesarean section by giving a permanent cure for the disproportion.

In cases of Breech-presentation with borderline pelves where trial of labour is not proceeding satisfactorily, the delay in many cases may be due to minor disproportion. Symphysiotomy performed prior to extraction of the baby will avoid the risk of intracranial haemorrhage. This is preferable to performing emergency symphysiotomy when difficulty has already arisen in delivering the after-coming head and damage may already have been done to the baby in an effort to deliver the head”.

## **1967 TRANSACTIONS**

**PROFESSOR DIXON (PROFESSOR OF OBSTETRICS & GYNAECOLOGY IN THE UNIVERSITY OF BRISTOL) :**

“The low incidence of symphysiotomy in all units have tempted me into venturing into a prophecy of what your invited speaker will have to show for symphysiotomy in 10 years' time i.e. 0.0%. There seems to me two possible explanations for this falling incidence, either you are adopting a United Kingdom policy in relationship to caesarean section and symphysiotomy, or improved nutrition in Dublin is bringing your patients' pelves into line with their United

Kingdom sisters. The figures from the Rotunda and the comments from the Coombe and the National strongly suggest that the latter is the true explanation. With regard to symphysiotomy for a breech presentation and a small pelvis, I can only take off my hat, bow and salute you. Personally I would do a caesarean section – even in Bristol”.

### *Disproportion*

These sections hardly merit comment. The incidence is much higher at the Rotunda than the National but whether this is due to a different population or more liberal criteria of diagnosis I do not know and on the data presented I am unable to formulate any opinion”.

### **BARRY**

“The words of Professor Dixon in relation to abruptio placenta were joy to my ear though I felt a little shocked when he spoke against symphysiotomy”.

### **PROFESSOR GAVIN:**

“We did four symphysiotomies in the Coombe last year – the results speak for themselves. I feel there is a place for symphysiotomy in obstetrics though it is very limited”.

### **O'DRISCOLL:**

“We performed the four Caesarean Sections in primagravidae for disproportion and we did no symphysiotomy. We had 1,500 primagravidae. The figures for x-ray pelvimetry in our Report include those outside the hospital and do not represent the number delivered in the hospital. We performed it very sparingly because it is not necessary. Any patient over 5ft tall in this country almost certainly has a normal pelvis.”

...

“With regard to vaginal delivery following a previous Caesarean Section, I hesitate to talk about this. I have seen patients who have to be transfused several pints of blood two or three hours after they have had a vaginal delivery after previous Caesarean section and I have seen patients nearly die from peritonitis in such cases. I agree with Dr. Gavin that it is better to examine the scar. As to prolonged labour, having got rid of the bogeyman of disproportion, prolonged labour to me is a completely manageable subject. I believe the duration of labour is entirely under my control”.

## **1967**

The Annual Report of the National Maternity Hospital noted 3 cases of symphysiotomy for disproportion. In the Coombe in 1967, 2 symphysiotomies were performed. No symphysiotomies were performed at the Rotunda in 1967. The Clinical Report noted:

*“ it is considered that symphysiotomy has a small but definite place in obstetric practice but there was no case considered suitable for the operation throughout the course of the year.”*

### **1967, National Maternity Hospital ACR, Master- O’Driscoll:**

Number of symphysiotomies        3

Cephalo-pelvic disproportion is not a common complication, but when it occurs it has serious implications for a young mother. Caesarean section imposes on her a choice between limiting her family or suffering several abdominal operations; symphysiotomy preserves her freedom of choice.

Symphysiotomy is considered in all primigravidae with cephalo-pelvic disproportion who are not more than 30 years old, and is performed when the disproportion is not of major degree and is mainly confined to the transverse

diameters. The first two cases described below are good examples of this. Case No. 3 represents the application of symphysiotomy to the multigravida, in whom the type of pelvic contraction is not so restrictive and in whom the results are most dramatic.

..”

### **1967 –The Coombe ACR, Master- William Gavin:**

Number of symphysiotomies        2

“The operation of Symphysiotomy was carried out on two patients during 1967. B. 1360. This patient was a 25 year old primipara whose previous pregnancy was terminated by caesarean section at 39 weeks in England, the baby weighing 7 lb. 3 oz. The section was performed electively because of disproportion. During her present pregnancy the head remained high at 36 weeks. An x-ray pelvimetry showed a gynaecoid flat pelvis with all characteristics average. True conjugate 9.2 cms., Transverse Diameter 12 cms. Prognosis very tight fit. No definite disproportion. It was decided to give her a trial of labour and probably do a symphysiotomy if necessary. The presence of a scar on her uterus complicated matters as our means of inducing labour would be limited because of this. However, her membranes ruptured spontaneously at term. Eighteen hours later the head was still high and vague pains were occurring. A Symphysiotomy was now performed under general anaesthesia. Good labour followed and she was delivered by forceps of a male lining infant weighing 8 lb. in good condition some 12 hours later. A wide episiotomy was performed prior to delivery to take the strain off the anterior vaginal wall.

There was no post-partum complications and both mother and baby were discharged well on the 12<sup>th</sup> day.

It should be noted that this baby weighed nearly 1 lb. more than her previous baby which was delivered by caesarean section and it is therefore regrettable



that she was not given a trial of labour with possibly a symphysiotomy in her first confinement.

...”.

**1966-1967 LOURDES ANNUAL REPORT (2 YEARS) G.A. CONNOLLY**

Number of symphysiotomies      31

“Thirty-one cases had symphysiotomy performed, an incidence of 0.67%. This incidence is increased from the last report published, when it was 0.55%. There was no maternal death or foetal loss. Seven cases were delivered by Lower Segment Caesarean section, symphysiotomy being performed after delivery, and during closure of the abdominal wound. One further case ((No. 568) had an elective symphysiotomy, but was delivered by section due to failure of the os to dilate. The remaining 23 cases all had symphysiotomy done in either the first or second stage of labour, and all these cases had vaginal deliveries of living infants. Included in these 23 cases are five cases of breech presentation. There are 16 primigravidae in this series, of which 12 had symphysiotomy done during labour with subsequent vaginal delivery”.

...

At the time of undertaking symphysiotomy, obtaining future vaginal deliveries is one of the aims...”

**1968, National Maternity Hospital ACR, Master- O’Driscoll:**

Number of symphysiotomies      4

“Symphysiotomy was performed on two primigravidae and two multigravidae. The disproportion was not relieved in two cases which were later delivered by

caesarean section and one perinatal death was caused by disproportion after symphysiotomy had been performed.

Successful symphysiotomy can be a very rewarding procedure in a young woman because caesarean section for disproportion commits her to abdominal delivery on every occasion; that it is not always successful, however, is shown by Case No. 1. The most dramatic results are seen in multigravidae with disproportion caused by a big baby, as illustrated by Case No. 4.

**1968 Rotunda ACR MASTER – EDWIN W. LILLIE**

Number of symphysiotomies      1

There was 1 case of symphysiotomy after arrest in an after coming head.

“.....Our policy with regards to breech presentation is to deliver all those associated with even minor pelvic contraction by Caesarean section. The fact that there were 3 cases of vaginal breech delivery is explained by two cases of hydrocephalus presenting by the breech and the remaining case was an unbooked multipara admitted in advanced labour. Pelvic outlet contraction was overlooked until it was found responsible for arrest of the after-coming head. An immediate Zarate symphysiotomy allowed relatively easy delivery and undoubtedly save the life of the baby (case No. 88710)”.

**1969, National Maternity Hospital ACR, Master- O’Driscoll:**

Number of symphysiotomies      2

“Symphysiotomy was performed after trial of labour had failed in two young primigravidae suspected of cephalo-pelvic disproportion. An adequate trial of labour was ensured by oxytocin infusion and in both cases disproportion was due to contraction of the transverse diameter of the pelvis.

The cases are described below. Disproportion was eliminated in the first but not in the second patient, who was subsequently delivered by caesarean section”.

### **Active Management of Labour**

Dr O'Driscoll of the NMH persistently signalled his belief that disproportion did not occur at the levels previously diagnosed. In 1969 he published a paper in the British Medical Journal of a retrospective study of 1,000 primigravid women in labour. His paper advocated that prolonged labour could be prevented by effective stimulation and by the abandonment of conventional obstetrical practices of non-intervention. The objective of active management was achieved by early diagnosis of labour; early intervention by artificial rupture of membranes; early and increasing infusions of syntocinon and close monitoring of foetal and maternal well-being.

### **Connolly in the Annual Report for Lourdes Hospital for 1968 & 1969:**

Number of Symphysiotomies	19 cases
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“...There has been a steady decrease in the use of symphysiotomy throughout the sixties. The operation was performed on a total of 160 cases with these results [over the years 1960-1969 inclusive] :-

Vaginal delivery	135 cases
Required caesarean section for various reasons	11 cases
Symphysiotomy “on the way out” after caesarean section	14 cases

This resulted in the loss of 9 babies which died because of :-

Congenital malformation	5 cases
Asphyxial death	3 cases
Traumatic I.C.H.	1 case

In **1970** the NMH reports no longer had a designated section for symphysiotomy.

### **Connolly 1970-71 Annual Report**

Number of symphysiotomies      26

*“the incidence of this operation has been unchanged over the last 8 years. However, the operation now is nearly always done in second stage of labour and never electively or during closure of the abdominal wound after a caesarean section”.*

### **1971**

**The Rotunda** ACR in 1971, Master Lillie:

Number of symphysiotomies      1

“...A fourth case of breech presentation escaped assessment of the pelvis during the pregnancy. This is unusual, as whenever possible all cases of breech presentation, whether primigravidae or multiparae, have either a clinical assessment or radiological pelvimetry performed. In this case pelvic evaluation was delayed and spontaneous labour started at the 38<sup>th</sup> week. At the time of labour the pelvic outlet and cavity were found to be satisfactory but as the breech was in the pelvis the brim was not assessed. Delivery of the trunk was performed without difficulty but arrest of the after coming head occurred due to brim contraction. A rapid Zarate symphysiotomy was performed and the delivery was then completed without difficulty. The baby weighed 3.860

Kilograms , made satisfactory progress and the mother had no after effects. This was the only case of symphysiotomy performed during the year and is, in our opinion, the only justification for the operation in a sophisticated community”.

#### **1972 ACR,National Maternity Hospital. Master - Declan Meagher**

Number of symphysiotomies                      2

“Ten cases of disproportion were recorded- an incidence of 0.4 percent. Delivery was by section in 9 cases and symphysiotomy in one case. This operation also failed in one case.”

#### **1972-1973 LOURDES REPORT (2 YEARS) – G.A. CONNOLLY**

Number of symphysiotomies                      15

“The incidence of this operation continues to decline progressively. In our view this is due to a decrease in the number of cases of disproportion, rather than other factors like the better management of labour. In the present series, twelve of the fifteen cases were operated on in the second stage of labour. Three of the operations were performed for breech presentation and in two of these the after-coming head was arrested at the brim. The operation was also performed for one brow presentation and one face presentation, both of which were delivered successfully.

Of the seven vertex presentations, four had brim disproportion and three had outlet disproportion.

Three cases were operated on in the first stage of labour. This undertaking of symphysiotomy in the first stage of labour is the exception in our view and may result in the wrong diagnosis of disproportion. Only one of these three cases

was delivered vaginally, the other two required caesarean section in both cases and in one of them, it is doubtful if there was any degree of disproportion at all.

There was no foetal loss in this series of cases and only two babies had low Apgar scores at birth”.

#### **1974-1975 LOURDES REPORT (2 YEARS) – G.A. CONNOLLY**

Number of Symphysiotomies	8
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“The incidence of this operation continues to decline progressively. In the present series all 8 patients were operated on in the second stage of labour. In two cases the operation was performed for breech presentation where there was arrest of the after-coming head at the brim of the pelvis. The operation was also performed for 1 brow presentation which was successfully delivered vaginally.

Of the 5 patients with a vertex presentation, 3 had brim disproportion and 2 had outlet disproportion. In one of the patients with brim disproportion vaginal delivery was not achieved following symphysiotomy and the patient had a Caesarean section.

There was no foetal loss in this series”.

#### **1976-1977 LOURDES REPORT (2 YEARS) –CONNOLLY**

Number of Symphysiotomies	9
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“There were 9 patients who had symphysiotomy performed in years 1976-1977. All 9 cases had the symphysiotomy performed in the second stage of labour.

In one patient the operation was performed for arrest of the after coming head in a breech delivery. In the other 8 cases the presentation was vertex, and in two of those there was brim disproportion.

There was no foetal mortality or morbidity in this series”

#### **1978-1979 LOURDES REPORT (2 YEARS) –CONNOLLY**

Number of Symphysiotomies	4
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“There were 4 patients who had Symphysiotomy performed in the years 1978 to 1979. All four cases had the Symphysiotomy performed in the second stage of labour. In 1 patient the operation was performed for arrest of the after-coming head in a breech delivery where a breech extraction was being performed for cord prolapse at full dilatation. There was no foetal mortality or morbidity in this series”.

#### **1980 LOURDES REPORT–CONNOLLY**

Number of Symphysiotomies	3
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“There was 3 patients who had Symphysiotomy performed during 1980. All three cases had the Symphysiotomy performed in the second stage of labour. In one patient the operation was performed for arrest of the after-coming head in a breech delivery. There was no foetal mortality or morbidity in this series”.

#### **1984**

The last 3 symphysiotomies were performed in Our Lady of Lourdes Hospital in 1984.

## GLOSSARY OF TERMS

### DEFINITIONS USED

Surgical Symphysiotomy: a surgical operation to enlarge the capacity of the mother's pelvis by partly cutting the fibres joining the pubic bones at the front of the pelvis.

Capsular Hypertrophy: general increase in bulk of capsule.

Cesarean hysterectomy: removal of the uterus at the time of cesarean delivery.

Dyspareunia: pain experienced during sexual intercourse.

Episiotomy: a surgical cut in the muscular area between the vagina and the anus - the area called the perineum - made just before delivery to enlarge the vaginal opening.

Gravid: a pregnant woman.

Primigravida: a woman in her first time pregnancy.

Iatrogenic: a morbid outcome of surgical intervention.

Lignocaine: a medication used *inter alia* to numb tissue in a specific area.

Morbidity: i. A diseased state.

ii. The frequency of the appearance of complications following a surgical procedure or other treatment.

Significant disability: *"medically verifiable physical symptoms and/or conditions directly attributable to the surgical symphysiotomy or pubiotomy and which have had a serious and debilitating effect on the Applicant's quality of life and include, but are not confined to, pelvic instability, pelvic pain, dyspareunia, urinary incontinence, back pain, pain on walking which continued for more than three years after the surgical symphysiotomy or pubiotomy."* (Terms of the Scheme)

Spontaneous symphysiotomy: where the pelvis widens to an abnormal extent during pregnancy and labour and develops a spontaneous morbid sub-luxation of the pubis symphysis and the sacro-iliac joints.

Subluxation: An incomplete luxation or dislocation; although a relationship is altered, contact between joint surfaces remains.



**Sclerosis:** the stiffening of a structure, usually caused by a replacement of the normal organ-specific tissue with connective tissue.

**Diastasis:** any simple separation of normally joined parts.

**Edema:** an accumulation of an excessive amount of watery fluid in cells, tissues, or serous cavities.

**Fistula:** an abnormal connection between 2 epithelialized surfaces usually caused by injury or surgery but can also result from an infection or inflammation.

**Vesico vaginal fistula:** is a subtype of female urogenital fistula which is an abnormal fistulous tract extending between the bladder and the vagina that allows the continuous involuntary discharge of urine into the vaginal vault.

**Arthropathy:** any disease affecting a joint.

**Osteitis:** inflammation of bone

**Osteitis pubis:** painful inflammation of the pubic bones near the mid line, sometimes due to repeated overload of the adductor muscles or repetitive stress activities.

**Osteophytes:** a bony outgrowth or protuberance

**Pelvimetry:** measurement of the diameters of the pelvis.

**Pelvic Ring or Girdle:** the bony ring formed by the hip bones and the sacrum to which the lower limbs are attached

**Pubic Rami:** pubic bones forming an angle with the main body of the hip bone.

**Puerperal:** relating to the puerperium, or period after childbirth.

**Pubiotomy:** severance of the pubic bone a few centimeters lateral to the symphysis, to increase the capacity of a contracted pelvis sufficiently to permit the passage of a living child.

**Symphysis Pubis:** the midline cartilaginous joint uniting the superior rami of the left and right pubic bones.

**Spondylolysis:** degeneration or deficient development of the articulating part of a vertebra.

**Spondylosyndesis:** binding together of an articulating part of a vertebra.

**Spondylitis:** inflammation of one or more vertebrae.

Sacro iliac joint: the synovial joint between the sacrum (part of the pelvis) and the ilium (flaring portion of the hip bone).

Translation: verical movement of the two halves of the joint.

## **ABRIEVATIONS**

UTI: Urinary tract infection

SPS: Symphysiotomy Payments Scheme

NND: Neo-Natal Death

SB: Stillbirth

NMH: National Maternity Hospital, Holles Street, Dublin

COOMBE: Coombe Lying-In Hospital, Dublin

ROTUNDA: The Rotunda

CUH Cork Universtiy Hospital

THE LOURDES: Our Lady of Lourdes Hospital, Drogheda, Co Louth

SIJ: Sacro Illiac Joint

RCPI: Royal College of Physicians in Ireland

RAMI: Royal Academy of Medicine in Ireland

IJMS: Irish Journal of Medical Science