Central European Journal of Nursing and Midwifery

Cent Eur J Nurs Midw 2023;14(3):924–933
doi: 10.15452/CEJNM.2023.14.0007

ORIGINAL PAPER

"In harmony" or "disoriented": Italian midwives struggling with epidural analgesia, an interpretive description

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Received July 19, 2022; Accepted April 27, 2023.

Abstract

Aim: The study aimed to describe the various ways in which Italian midwives reconcile their profession's philosophical views about labor with the use of epidural analgesia in clinical practice. *Design:* Interpretive description. *Methods:* A purposeful sample of 41 midwives and 12 midwifery students participated in the study. Information about their perceptions and experiences of the use of epidural analgesia and how this practice aligns with their professional values were explored through in-depth interviews (n = 10 focus groups; n = 1 one-to-one interview). The constant comparative method was used to analyze the data. *Results:* With respect to aligning midwifery care with the administration of epidural analgesia, two midwifery positions were identified: the midwife that acted "in harmony" and the "disoriented midwife", defined by three dimensions: 1) the midwife's conception of her professional role; 2) the woman's attitude towards labor and; 3) the midwife's relationship and comfort with other professionals in the labor room. *Conclusion:* The results of this research highlight how difficult it can be for a midwife to reconcile a specific philosophical view of labor with the use of epidural analgesia. These findings can provide useful insights to help midwives in the challenging task of combining epidural analgesia with their philosophical view of labor to offer a better birth experience to women.

Keywords: epidural analgesia, interpretive description, midwife, midwifery philosophy.

Introduction

In Italy, pregnant women are typically admitted to hospital in the first stages of labor, where registered midwives are present to deliver infants, provided births are uncomplicated. Within the context of Italian hospitals and the fragmentation of care during childbirth, hospital protocols require that women are admitted to the hospital only when in active labor, which is one of the elements that enhances the tension between two models of care: the biomedical model and the natural midwifery model of care.

This means that midwives are required to consistently balance the tensions of working within these two diverse models of care (Spina, 2009; Perrotta, 2010). The two approaches to care are underpinned by diverse philosophical assumptions and traditions of knowledge (Rooks, 1999). The biomedical model includes a focus on and a prioritization of identifying potential risks of childbirth. It "prepares for the worst" (Rooks, 1999) and, often, clinicians working within this model put their trust in technology to promote good outcomes for women and their infants. In comparison, the natural midwifery model of care focuses mainly on birth as a "natural process that has profound meaning to many people and should be treated as normal until there is evidence of a problem" (Rooks, 1999). These two models give different interpretations to labor pain. The biomedical model associates pain with trauma and illness; therefore, labor pain may be perceived as pointless and dangerous – as something to be alleviated (Perrotta, 2010). By contrast, the midwifery model views labor pain as natural since it helps the woman understand how to help her baby. Pain is something every woman may experience during labor and, "it is not something to be feared" (Vague, 2004), but rather "something to work with" (Vague, 2004). Midwives are constantly navigating the task of delivering their care while experiencing the tension of working within these two different models.

In 2005, the International Confederation of Midwives (ICM) published a report entitled,

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"Philosophy and Model of Midwifery Care" that provided an in-depth description of the midwifery profession's view and approach to childbirth. In this description of the midwifery model of care, it is stated that, "Midwives respect and have confidence in women and in their capabilities in childbirth; and midwives promote and advocate for non-intervention in normal childbirth" (ICM, 2005). In summary, this statement provides a general overview of the profession's position towards the medicalization of birth (ICM, 2017).

The biomedical and natural models of care are not mutually exclusive; the labor room is a "room of struggle" (Blaaka & Shauer, 2008), in which these two traditions co-exist. Every midwife must find her own midwifery style while confronted with these two different approaches, and she "must learn to find a good balance between active management and respect for birth's own rhythm" (Blaaka & Shauer, 2008); she must learn when it is time to wait and when it is time to take action. Provision of care that is consistent with the midwifery philosophy of care may be impacted by the models of care a midwife works within. It is suggested that working in a fragmented and medical model is associated with the midwife being "for the institution" rather than "for the woman" (Bradfield et al., 2018). The introduction of epidural analgesia as a method of pain relief during childbirth complicates this scenario.

In the United Kingdom (UK), over one-third of laboring women choose epidural analgesia for pain management during labor. In the United States (US), 40% of laboring individuals opt for the epidural, and in Sweden, percentages range from 30% to 50% (Saperidoc, 2011). National data for Italy is not available; however, in the Emilia-Romagna region, the context for this study, the number of administered epidurals rose from 6.9% in 2007, to 17.3% in 2013, and to 24.5% in 2020 (Regione Emilia-Romagna, 2021).

Epidural analgesia is now the most popular pharmacological method for pain relief during labor in Western countries (Anim-Somuah et al., 2018). Information and evidence on this technique, its risks and benefits (Anim-Somuah et al., 2018), and the experience of women delivering with an epidural has been extensively documented (Cheng et al., 2020; Hidaka & Callister, 2012). However, only a few studies have focused on how the epidural has modified and challenged the midwifery model of care since it embraces the biomedical philosophy of childbirth. The increased use of epidurals during childbirth raises questions about how congruent this method is with the midwifery philosophy, and there is a lack of understanding regarding how midwives address the challenge of integrating epidural analgesia into their approach.

There are relatively few studies that have examined this phenomenon. Payant et al. (2008) highlights how midwives tend to provide less emotional support to women laboring with an epidural and even spend less time in the room with them. Graninger and McCool (1998) provide foundational information documenting midwives' perceptions of epidural analgesia. Their results are contradictory: midwives recognize labor pain to be a crucial element in the process of becoming a mother but, on the other hand, they might recommend women to have an epidural without medical indication. Moreover, midwives claim to be concerned about the increasing rate of women who ask for an epidural during labor; yet they do not perceive analgesia to be in conflict with the midwifery model of care. Both studies concluded that more research is needed to increase our understanding of the intersections between the administration of epidural analgesia during labor and the midwifery model of care. It would seem that while research on women's experiences of laboring with epidural is ongoing, this does not apply to midwives' experience of assisting women laboring with epidural.

Aim

The study aimed to describe the various ways in which Italian midwives reconcile their professional philosophical views about labor with the use of epidural analgesia in their clinical practice with women who are laboring. The overarching research question of this study was: "How do midwives and midwifery students, working in Italian hospitals, reconcile their professional philosophical view of labor and labor pain with the use of epidural analgesia during labor?".

Methods

Design

The principles of interpretive description methodology (Thorne et al., 1997; Thorne, 2008, 2013, 2014) guided all sampling, data collection, and analysis decisions in this study. This approach to applied qualitative health research is typically used to answer research questions derived from clinical practice; then to use the methods to generate new knowledge which can be applied to resolve or better understand these practice issues. Since this study was conducted through the disciplinary lens of midwifery, use of this methodology also allows

for the generation of meaningful disciplinary knowledge. Furthermore, while allowing for the description of the phenomenon under study, use of inductive approaches to analysis in an interpretive descriptive study also facilitates opportunities, through interpretation, to explore the different ways in which individuals (in this case, midwives) experience and understand the phenomenon of interest.

Sample

In Italy, it is typical for most women to deliver their infants in labor and delivery units within a hospital or birthing center. Within the hospital setting in Italy, registered midwives are responsible for supporting individuals through all stages of labor (involving uncomplicated births) up to the delivery of the infant. Registered midwives are also trained to provide comprehensive prenatal and postpartum care. This study was conducted in four hospitals located in the Emilia-Romagna region of north-east Italy. These four hospitals were specifically selected as places to recruit the midwives and midwifery students since they differ across a number of variables including: number of births / year; years of experience in offering epidural analgesia; number of midwives per shift; and designation (or not) as a teaching hospital. Recruiting participants from such diverse care settings provided an opportunity to ensure that a broad range of experiences were exploited and philosophical views of epidural analgesia could be explored.

A purposeful sample of midwives and midwifery students with a solid understanding of midwifery's professional values and who were familiar with the administration of epidural analgesia during labor were invited to participate in this study. The study inclusion criteria were: 1) a registered midwife with at least three years of experience, or a midwifery student enrolled in their final year of studies; 2) experience providing midwifery care to women who received epidural analgesia during labor; and 3) ability to speak Italian. The inclusion of both experienced midwives and senior midwifery students in this study created an opportunity to explore how perceptions varied according to level of experience, and immersion in the profession. To achieve informational power (Carnevale, 2002), our a priori sample size estimate was 40 participants, with approximately 30 registered midwives and ten midwifery students. Information about the study was shared by the lead author (ET) with the chief midwives in the four participating hospitals; the opportunity to participate in the study was then communicated to the midwifery teams working in each setting. By agreement with a professor in a university midwifery program, convenience sampling was employed to recruit the midwifery students.

A study information sheet was provided to each individual; each study participant reviewed and signed a consent form prior to participation.

Data collection

To first understand the participants' professional values and then to explore how these values align with the use of epidural analgesia during labor and delivery, data were generated through the conduct of focus group interviews. Facilitating the discussion through focus groups provided the participants with opportunities to describe how different contexts of care influence their thoughts and experiences with epidural analgesia; again, providing us with an opportunity to document the different variations, dimensions, and patterns of their experiences. The opportunity to participate in a focus group was arranged at each hospital site (in a location separate from the labor and delivery unit, as a strategy to maximize confidentiality); at least two meeting times were arranged at each hospital location, to maximize opportunities for midwives to participate. It is important to note that one midwife participant was unable to attend the scheduled focus groups at her site; however, as she expressed an interest in participating in the study, the option for her to complete a one-to-one, semi-structured interview was offered. This option was available for other participants who preferred to share their experiences privately rather than in a group. One focus group was arranged for the midwifery students to participate in at the university.

A total of ten in-person focus groups overall were completed from October to November 2014. At the hospital sites, a total of nine focus groups were completed with two-seven participants (mean number participants per focus group = four) per focus group (mean length of interview = 68 minutes). One focus group, with 12 students, was conducted at the university (length of interview = 60 minutes). All focus groups were facilitated by the principal investigator (ET), who was responsible for data collection and analysis in this study, and who was a midwife with more than ten years of experience working with pregnant individuals and providing hospital-based midwifery care in Italian labor and delivery units. In addition to her clinical expertise, she also had extensive experience in designing and conducting applied qualitative health research studies. Within each focus group, open-ended questions were asked, and participants were asked

to reflect on their experiences working with women who receive epidural analgesia during labor, how this medical procedure aligned with their professional values, and how the administration of this treatment influenced the midwifery care provided (questions summarized in Table 1). All focus groups were audiotaped with the permission of the participants. All participants completed a demographic questionnaire following the focus group. Field notes were maintained and completed following each focus group. During all phases of data generation and analysis, the lead author maintained a reflective journal; opportunities for debriefing and discussing difficult clinical issues that arose in the interviews were then shared and discussed as an opportunity of for reflection during the analysis phase with her research supervisor.

To achieve trustworthiness, ET kept a reflective journal and field notes after every focus group / interview and, according to the "thoughtful clinician test" (Thorne, 2008), findings were discussed for consistency by an experienced midwife not involved in the study. ET was aware of the difficulties encountered by many midwives during labor care with epidurals, and she could see that colleagues used different approaches. To provide an opportunity for discussion and reflection on these concepts, the first author arranged meetings for reflection with her academic supervisor.

Table 1 Summary of interview questions

Interview questions
1. Epidural analgesia and midwifery, what are your thoughts on that?
2. What are the philosophical beliefs of care that you hold? How do these values / beliefs align with the care you provide?
3. What are the challenges of caring for a woman with an epidural?
4. What are the benefits of caring for a woman with an epidural?
5. How do you care for women in epidural analgesia during labor?

Data analysis

All interviews were recorded and transcribed verbatim with identifying information removed. Each transcript was then read in its entirety. Data were coded and synthesized using an inductive approach to qualitative analysis, with a focus on applying the constant comparative technique. In interpretive description, Thorne emphasizes the need not to be overwhelmed by data coding. According to Thorne et al. (2004), data analysis starts with a researcher who knows the cases deeply, but then moves from a descriptive level to a more interpretive one. The interpretive levels require the researcher to take a position on the data analyzed, by asking questions such as "what is happening here?" and "what am I learning about this?" (Thorne et al., 1997). This process is essential in "generating 'findings' that have the potential for credibility or 'interpretive authority', beyond the artistic license of the individual author" (Thorne et al., 2004). The researcher prioritizes data interpretation more than description, and generates categories and themes informed by their disciplinary lens. The constant comparative method is suitable for the scope of this research as it highlights similarities and differences between the cases and helps move towards an interpretive level. Categories, followed by themes from the first two focus groups were developed and used to guide the analysis of subsequent transcripts. As new categories were developed, the researcher returned to prior transcripts to compare and contrast findings and explore whether different variations, dimensions, or properties of the phenomenon of interest could be identified. Throughout the data analysis phase, the "thoughtful clinician test", a strategy specific to interpretive description was employed (Thorne, 2008). In this step, the researcher shared the categories and themes under development with an experienced midwife (who was not a study participant) to ensure that the interpretive descriptions being developed were plausible and reflective of midwifery practice.

Results

Following ten focus group sessions and one interview, 41 registered midwives and 12 midwifery students (study total sample = 53) were enrolled in the study (Table 2). This purposeful sample of registered midwives and midwifery students were well positioned to speak about the experiences of providing care to women who received epidural analgesia during labor, since a majority of midwives (73 %) and all of the students had received training on epidural analgesia. However, it is important to note that this training focused on the characteristics and medical administration of epidural analgesia, and not an exploration of how this option could be embedded within midwifery practice. Additionally, most of the midwives had a long history of working in care environments in which

epidural analgesia was a treatment option; 39% of participants (n = 16) worked in hospitals in which epidural analgesia had been available for more than 15 years, and the remaining 61% of the sample indicated that this option for pain relief in labor had been available to women in their hospitals for the last five-eight years.

Across study participants, two polarized attitudes held by midwives towards the use of epidural analgesia were identified: 1) the disoriented midwife and 2) the midwife in harmony. The dimensions of these two theoretical constructions were developed and defined as follows:

- The midwife's conception of her professional role.
- The expectant woman's attitude during labor.
- The midwife's feelings towards having other professionals (especially anesthetists and obstetricians) in the labor room.

Table 2 Demographic characteristics

		Registered midwives n = 41	Midwifery students n = 12
Age (mean)		35 (28–56)	23 (23–26)
Mean years' experience as a midwife (range)		10 (4–33)	N/A
Mean years' experience working in labor and delivery room (range)		8 (2–27)	N/A
Participants with specialized training in epidural analgesia (%)	yes	30 (73)	12 (100)
	no	11 (27)	0 (0)

N/A – not applicable

First, these two basic paradigms will be discussed and then the three dimensions that contribute to the identification of the two paradigms will be explained.

The "disoriented midwife" has a negative attitude towards epidural analgesia, since she finds it very difficult to accept unconditionally a women's choice to have an epidural. Typically, midwives that hold this position believe that that every woman has enough endogenous resources to face labor pain on her own. Moreover, the "disoriented midwife" believes that women who have an epidural need less emotional support. On the other hand, she thinks that removing labor pain is not, in itself, sufficient to eliminate the fear of labor and becoming a mother.

The "disoriented midwife" believes that labor with analgesia is much more difficult than without epidural, since he / she cannot rely on signs (such as the urge to push or a woman choosing a particular position) to confirm that labor is proceeding in a physiological way. Moreover, this kind of midwife perceives that there is a conflict between her professional understanding that every woman has the potential to face labor pain and the need to support women who opt for an epidural. The "disoriented midwife" believes that epidural analgesia reduces her professional position, and she finds it hard to tolerate any interference, particularly from anesthetists, in her field of activity.

In this situation the "disoriented midwife" feels useless and passive, especially during the first stage of labor. She finds the second stage to be very difficult and tiresome. Since epidural analgesia moderates the signs and symptoms (such as the urge to push) that usually guide women through labor, the midwife must tell her what to do and, hence, becomes very directive. The "disoriented midwife" finds this role quite demanding. Fatigue and frustration are even stronger when the midwife is required to explain to the expectant woman what she should feel and do since the woman cannot perceive what is happening to her own body.

In comparison, the "midwife in harmony" has a positive and welcoming attitude towards analgesia and believes that she can fulfil her professional role even in labor with epidural.

This model of midwife prioritizes the principle that it is the woman's choice whether to have an epidural or not. The "midwife in harmony" is aware that the current Italian organizational model does not give women and midwives the opportunity to develop a therapeutic relationship prior to the start of labor. Hence, midwives working in delivery wards can only accept the decision women make during labor, usually with little information and deliberation. The "midwife in harmony" is guided mostly by the principle that the choice of how labor pain is managed belongs to the woman and that the midwife must unconditionally accept her decision. Moreover, the "midwife in harmony" thinks that the conflict with epidural analgesia is more a problem for midwives than women. This midwife has positive relationships with other professionals, since she recognizes that everyone has specific skills in the labor room.

The "midwife in harmony" does not find labor with epidural analgesia more or less difficult than natural

labor; she merely regards it as different, since there are differences and specific aspects to consider. In other words, this midwife activates "a mental pathway of things to do" (FG 1) connected specifically to labor with epidural. During labor, the "midwife in harmony" puts her knowledge and competence at the woman's disposal, no matter what she requests.

All midwives move on a *spectrum* that runs from "disoriented" to "in harmony" regarding analgesia and adapt in response to concrete and specific situations that happen in every labor room. This means that a midwife can be "disoriented" in some situations and "in harmony" in others, if one or more of these dimensions change.

The three dimensions – the midwife's conception of her professional role, the expectant woman's attitude during labor, and the midwife's feelings about having other professionals in the labor room – help us to understand the elements that position midwives between these two unique models of care.

Midwives' conception of their professional role

In examining midwives' conception of their professional role, two concepts emerged: the *resilient midwife* and the *switched off midwife*. The first defines the "midwife in harmony", and the second defines the "disoriented midwife".

The *resilient midwife* does not experience any professional conflict with epidural analgesia since she believes it is a woman's personal choice and this enables her, as a midwife, to be more in tune with what the woman wants. For the *resilient midwife*, there is an understanding that the laboring woman's choice prevails in this decision-making context, knowing that professionals cannot contest it in any way since they do not know the personal and intimate reasons behind that choice. The goal of the *resilient midwife* is to ensure that the woman has a positive birth experience and not to promote her personal beliefs about birth.

The *resilient midwife* believes the midwife's role is to accept women's desires about their labor. This kind of midwife carefully monitors all the technical aspects that may change with an epidural, such as good pain management, bladder emptying, and movement. This midwife finds herself collaborating with all other professionals who work with her in the labor room. This kind of midwife does not find it difficult to be directive towards the woman when necessary. One midwife in this study explained how she built trust and cooperation with the woman, and how she prepared the woman in advance for the second stage of labor: *"I do explain it very clearly at the beginning of labor. I tell the woman that the first stage is like this and this … she can rest any time, she can stay in any position she likes; I suggest that she rests, drinks, and gathers her strength, because when the second stage starts, it will be very demanding. I prepare them psychologically from the very beginning; they know what will happen [laugh]. I take preventive action, and usually they agree. I do not say: 'OK, now it's time to push', close to the second stage, and I tell them that it is not possible to deliver without feeling a thing, even with an epidural. And during the second stage they have to work hard as well, even if the pain is not there"* (FG 4).

The *resilient midwife* does not feel threatened in her professional identity by the eventual detachment that a woman can experience with respect to physical birth sensations. The midwife knows that the choice of having an epidural is not her concern – she must simply adapt to the woman's wishes. The midwife is there to help and support the woman, and she does not feel uncomfortable if the woman is asleep or disengaged during the dilation phase. Additionally, neither does she feel uncomfortable adopting a more managerial attitude during labor, if necessary. The *resilient midwife* can adapt to all changes that an epidural brings to the labor room.

In contrast, the *switched off midwife* feels *"less a midwife, and more useless"* (FG 5) when assisting a woman after epidural.

For the *switched off midwife*, a woman's decision to accept an epidural is often perceived as a threat to her professional identity. The decision to use this mode of pain relief method fundamentally influences the midwife's attitude towards the woman during labor. On one hand, without analgesia, the midwife reassures, supports, and encourages the woman throughout the whole birth process and helps the woman to express herself to her full potential. On the other hand, when an epidural is initiated, the midwife is required to assume a different attitude towards the woman in the first and second stages of labor. In the first stage, she has a supervisory role, perceived as a diminished role in comparison to that during labor without epidural. The woman, experiencing no pain, feels more detached from the challenges of childbirth and tends to chat or spend time on electronic devices.

When an epidural is given, the midwife turns into a supervisor, a sentinel, a storyteller, or a "maid of honor" (since she must make conversation with the expectant mother during the long hours of labor). Particularly during the first stage of labor, the midwife feels redundant and tends to spend less time in the same room with the expectant woman;

the relationship with the woman is more verbal and less physical. During the second stage of labor, the midwife must be more active, even directive – to make up for the woman's own lack of sensations and feelings. This is due to a woman's limited perception of the baby's progression through the pelvis and the urge to push; hence the midwife must explain what she should do or feel to help the baby to be delivered. This situation frustrates the *switched off midwife*, who believes that every woman naturally knows how to deliver her baby. In many ways, the *switched off midwife* does not recognize this approach to care as traditional midwifery care.

The *switched off midwife* continuously looks for signals that are typical of labor without analgesia and tries to project them onto a labor with epidural. She prioritizes the mother and baby relationship and wants the mother to keep her focus on the experience of birth she is going through. Her sense of frustration seems to originate from the challenge of recognizing typical aspects of physiological labor, to the point where she changes her attitude when she encounters elements of her ideal of physiological labor, becoming more welcoming and positive.

Yet, for both *resilient* and *switched off* midwives, it is vital that every woman has a good birth experience and sees herself as the true protagonist of her childbirth experience.

The expectant woman's attitude towards labor

It was the perception of participants in this study that women who chose epidural analgesia lived this experience very differently. The participants explained that the reasons for making this choice were different, and that each labor experience was unique. The woman's attitude once an epidural is given can influence the midwife's attitude towards the epidural itself.

From analysis of the focus group discussion, it was possible to identify two different approaches in women: delegation or involvement. The first plays to the "disoriented midwife", the second the "midwife in harmony."

When a woman assumes a delegating attitude, she is perceived to be more detached from the experience of childbirth and from the physiological changes her body is experiencing. These women are described by midwives as static, difficult to activate and engage, and not motivated to put in the hard work of labor (necessary in the second stage). According to one midwife, there is a belief that they have now handed over responsibility for this hard labor to the birth professionals: *"Now that I've had it [epidural], they'll deliver my baby"* (FG 9).

When women have this attitude towards labor, it places the "disoriented" midwife in a position where she must put mechanisms of activation in place, and in some situations, become very directive in order to gain women's cooperation, particularly in the second stage.

Midwives who participated in the focus groups discussed how women tended to have two approaches towards labor: to either delegate or be actively involved. When a woman delegates, her midwife is more likely to fall into the "disoriented" category. If the expectant woman feels involved, her midwife is more likely to be "in harmony".

For a woman who delegates, pain control is paramount. She delegates the delivery of her child to the professional. She is distant and detached from what is happening to her body and her baby. The midwives involved in the study report a conflict between the point of view of the midwife and the woman when the midwife attempts to involve and activate someone who wants to stay at one remove from what is happening to her body. Thus, this tendency creates a "disoriented midwife", a perspective and attitude described in detail by one midwife: *"Didn't you ask for an epidural? So help yourself then! Sometimes … I'm unwilling … I mean … it's pointless … to use the ball, the hand-knee position … Am I mean? I know I am, but we spend so long supporting these women … that sometimes I wonder why I'm doing such a stupid thing. I am self-critical! Because … when you meet these women who have labored all night long … lots of syntocinon, … and when I arrive, I find her, like a pietà [the statue by Michelangelo], sprawled out on the bed, lots of Naropin, many and many 'top ups' … And at seven, you have to tell this woman 'hello, here I am … wake up … let's go to the wall bars, lets squat a little bit, let's go to the toilet', when she's had a catheter in for the whole night because she could not even feel her legs. She wanted a kind of birth, she decided some things about her birth, and then she has a different one!"* (FG 11).

Some participants' narratives recount that once free of pain, their level of activity and engagement in the second and third stages of labor actually increased. Midwives described these women as involved, or active and motivated to follow directions and guidance and do anything possible to support the delivery of the baby. Midwives working with "involved" women experience a sense of harmony since the women were able to freely chose to have an epidural and, even in the absence of pain, are motivated to fully engage in the childbirth experience. This aligns with the concept

of the "fear-free woman", or the individual who has purposefully chosen analgesia as a practical tool that enables her to be more lucidly involved in her birth experience (Jepsen & Keller, 2014). As one experienced midwife further explained: *"Sometimes […] you have epidurals that are administered correctly. The expectant woman can move [she has enough strength in her legs], she can feel the urge to push, and she can feel her baby. These women do what you suggest to them, they have not had too many drugs … and … in these cases, as a midwife, you are satisfied with this labor…even if there is an epidural, you are satisfied"* (FG 6).

The midwife's relationship with other professionals in the labor room

Other than midwives, two main professionals intervene in the labor room when an epidural has been administered: the obstetrician and the anesthetist. During the focus groups, the midwives described their relationship with the anesthetist as somewhat problematic. The main issue stems from the anesthetist's medical and technological approach to labor pain – far from the midwife's conception of it as a physiological aspect of labor.

The relationships that are established between the midwife and the anesthetist and / or obstetrician fall into two categories: conflict and cooperation.

If the relationship is driven by conflict, the result will be a "disoriented midwife"; on the other hand, when there is cooperation, the midwife is able to be a "midwife in harmony".

The first situation occurs if the midwife feels that the anesthetist is invading her field of competence and responsibility. This happens when the anesthetist comments on decisions made by the midwife, or when the obstetrician decides that it is necessary to accelerate the progression of labor or overrides the midwife by suggesting positions to the woman or even questioning the midwife's cervical examination.

In contrast, cooperation is achieved when the anesthetist and / or obstetrician and midwife share the common goal of a "good birth", and work together by offering and respecting each other's expertise. They usually ask many questions so that everyone knows what is happening, and they help each other understand what stage the labor is at. As one midwife explains: *"Sometimes it happens: there is cooperation. They [The anesthetists] ask 'what is the baby's heart rate?'. Or when you call them for an epidural […], they put the catheter in and ask: 'Is it time for a bolus? Do I need to give her Fentanest? Is the baby's heartbeat reassuring?'. Only yesterday I had the opportunity to work with an excellent anesthetist … It was a pleasure to work with him!"* (FG 9).

Discussion

The focus of this study was to describe the various ways in which midwives reconcile their philosophical views on labor with epidural analgesia. The results indicate two basic paradigms: the "disoriented midwife" and the "midwife in harmony". These results add to the debate on the physiology / technology of childbirth described by many authors (Blaaka & Shauer, 2008; Smeenk & ten Have, 2003), and highlight how important it is for midwives to demarcate physiology as their area of authority. However, labor with epidural analgesia is a grey area, neither completely natural nor completely medicalized (especially from expectant women's point of view) (Waldenström, 2007). This study describes the struggle midwives experience when caring for women laboring with epidural. Moreover, it identifies three dimensions that lead to midwives becoming either "disoriented" or "in harmony" with regard to epidural analgesia. One of which is the expectant woman's attitude during labor.

The available studies highlight some important information concerning women's experience of laboring with epidural analgesia. From one, we learn that 88% of women who requested an epidural for pain management reported being less satisfied with their childbirth experience than those who did not, despite lower pain intensity (Kannan et al., 2001), and "women who used medication were more likely to experience negative side effects, negative encounters with healthcare providers, and a sense of guilt and / or failure" (Thomson, 2019). Hodnett et al. (2011) have suggested that the attitude of healthcare providers can be crucial in determining women's satisfaction with the birth process. This raises new questions regarding what constitutes good midwifery practice for women with epidural. The findings illustrated in this study emphasize how women's active attitude towards labor (once pain is removed) can help midwives feel "in harmony" with epidural analgesia. However, some women feel detached from what is happening to their body and baby – an attitude that may result in a "disoriented midwife". This conclusion is remarkably similar to what Jepsen and Keller (2014) describe when discussing women's experience of giving birth with epidural analgesia. In some cases, the epidural analgesia removed the woman from the experience of labor ("worriedwomen"), while others felt more involved and "in control". Moreover, Jepsen and

Keller (2014) described a change in the woman-midwife relationship before and after an epidural. Even if the midwife has been caring and supportive during painful contractions up to this point, she becomes instantly more distant and "formal". This aspect can be explained through the dimension of "The midwife's conception of her professional role". Midwives strongly believe in non-interventionism when it comes to a physiological childbirth (ICM, 2017) but epidural analgesia requires that they change their approach as described in the findings. The switched off midwife has difficulty reconciling the introduction of medicalization through epidural analgesia with the philosophy of normal birth. While the resilient midwife has found a balance between these two important aspects of caring. Interestingly Drach-Zahavy et al. (2016) suggest that two rival perspectives dominate today's birthing rooms with regard to the approach to pain relief during labor. One holds that laboring women should avoid epidural analgesia due to the advantages labor pain provides in terms of sense of control, and feelings of success and empowerment. In comparison, there are midwives who insist that a laboring woman using pain relief is more cooperative. In their study on the emotional effort put in by midwives in the labor room, Drach-Zahavy et al. (2016) describe the dual approach a midwife can take with a woman who chooses to have an epidural. The job demands intense emotional effort from every midwife (Drach-Zahavy et al., 2016). The emotional effort reported by Drach-Zahavy et al. (2016) is that described by the midwives involved in this piece of research. This study helps describe the struggle midwives face to reconcile their professional view of normal birth with the medicalized vision of birth. Midwives move on a spectrum from "disoriented" to "in harmony". These two basic paradigms are theoretical constructions that help generalize the phenomenon under study and are helpful in describing the difficult work that it is required of midwives in finding a new perspective that can reconcile these two conflicting views of labor pain and philosophies of birth. Three dimensions emerged which make it possible to qualify a midwife as either "disoriented" or "in harmony" with epidural analgesia. The three dimensions are: 1) The midwife's conception of her professional role; 2) The expectant woman's attitude during labor; 3) The midwife's feelings towards having other professionals (especially anesthetists and obstetricians) in the labor room. Interestingly, during data analysis, no difference emerged between the perceptions of professional and pre-professional (e.g., student) midwives. These results indicate how all the subjects involved in the labor room play a role in determining the philosophy of birth adopted. If there is a balance of power and ideas, and a genuine acceptance of all possible views on labor pain, the midwife can feel free to express her professional view and knowledge. Otherwise, as described by Fahy and Parratt (2006) in "the birth territory theory", there is one force trying to override all others.

Conclusion

The conclusions described in this study can be helpful both for students and for experienced mid-wives. Every midwife must find her own way to combine professional / philosophical views on la-bor with epidural analgesia. The findings of this study can help every midwife who struggles to reconcile epidural analgesia with the philosophy of midwifery. Finally, it would be interesting to use the analysis of the three dimensions that contribute to the definition of the two basic paradigms of midwife as an instrument for enhancing the quality of the services offered, particularly during training of new and experienced midwives.

Ethical aspects and conflict of interest

This research study received approval from the degree board of the University of Bologna. The authors declare that there was no conflict of interest.

Funding

This research received no specific grant from any funding agency, commercial or not-for-profit sectors.

Acknowledgements

Authors would like to thank all midwives and students who kindly agreed to participate in this research.

Author contributions

All authors contributed to the conception and design, data analysis and interpretation, manuscript draft, critical revision of the manuscript, and final approval of the manuscript. ET was responsible for data collection.

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