ARTICLE

USING A NARRATIVE CASE STUDY TO FACILITATE A HOLISTIC MIDWIFERY CARE: A TEACHING STRATEGY

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ABSTRACT

Ten years ago a follow-up woman programme to assist midwifery students to enhance holistic midwifery care was implemented at a university in Gauteng Province, South Africa. Each student had to select a woman (family) to accompany during pregnancy, delivery and six weeks postnatally. The aim was to use a case study as a teaching strategy in midwifery nursing education in an attempt to ensure that students are responsive to a pregnant family by means of a holistic approach. The purpose of this article is to share the narrative experience of a midwifery student and the pregnant family, and to present the lived experience of the student as a form of evaluation of the programme. A narrative case study design characterised by human-to-human interaction and participant observation was followed. A narrative analysis of the student's experience led to the development of themes. The findings are consistent with a conscious act that conveys a will and an intention to care as the student empowered the woman to gain knowledge, self-care, self-control, self-healing and self-actualisation. The journey offered a systematic observation of the midwife's own and the woman's experience and inner subjective processes of a lived experience that justified the importance of the programme.

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INTRODUCTION AND BACKGROUND INFORMATION

The article shares a student midwife's account of a case study as a learning experience and how the provision of holistic antenatal care was realised. "Narrative" refers to a kind of an event expressed in story form, a scheme by means of which individuals give meaning to their experience of personal actions (RCN 1998,35). In this study, the student reveals awareness of the importance of the biopsychosocial well-being of an individual by reflecting on the traditional routine antenatal care offered to pregnant women. Cox (2001,862), on investigating narrative analysis from a medical perspective, argues that stories provide a link between objective and subjective details and are an important strategy for learning.

Childbirth constitutes a major event in a woman's life during the perinatal period, and the mother, her partner and her family face the possibility of physical, psychological and social upheavals. Perinatality is a period during which the use of health-care services should be intense to ensure the woman and the baby's well-being (Rodríguez and Des Riviéres-Pigeon 2007,1).

As stated by Fraser, Cooper and Nolte (2009,239), some aspects of pregnancy and labour can be affected by psychosocial factors, and as such, attention should be focused on the reduction of stressful psychosocial demands placed on the expectant woman, as psychosocial risks may impact the biological well-being of the woman.

Holism, in the context of the study, refers to understanding and managing pregnant women as a whole being, rather than breaking down, studying or treating only the component parts (Tjale 2007,5).

PROBLEM STATEMENT

Midwives are mostly confined to routine care that emphasises the physiological aspects of pregnancy. However, pregnancy involves intense emotional, spiritual, psychological and social factors that need a midwife's caring awareness and responsiveness. A pregnant woman should, as such, recognise and incorporate these changes into her self-image, her social network and her lifestyle with the assistance of a midwife. As stated by Mitchell and Egudo (2003,2), a narration is an interpretive approach in the social sciences to aid in education, with the truth being grounded in everyday life. Everyday life involves interactions among individuals, a postmodern approach that emphasises the social nature of knowledge creation. The researcher's observation as a nurse educator is that a case study, as a teaching strategy, is widely used in nursing education institutions, but in a non-narrative form.

THE PURPOSE AND OBJECTIVE OF THE STUDY

The objective of this paper was to explore a case study as a teaching strategy, and the purpose is to enhance a holistic approach in the caring for pregnant women.

METHODOLOGY

A narrative case study was used as an exploration and in-depth analysis of the student's experience. The student had to choose a pregnant family and accompany them from pregnancy until postnatal care. The criteria for choosing the family were also specified: the woman should be in her first trimester of pregnancy, be willing to participate, and should be residing within reach of the student for home visits. The narrative case study incorporated the three types of case studies as described by De Vos, Strydom, Fouche and Delport (2009,272), namely, that it is intrinsic by aiming at gaining a better understanding of the individual, instrumental whereby there is an elaboration on a theory, and collective in a sense that the case study furthers the understanding of a phenomenon, which is childbirth, within the context of this study. Narration is interpretive and reflective. Its reliability and validity lie within the one telling the story (Druckman 2005,4). A narrative analysis of the student's experience led to the development of themes that are discussed under findings.

NARRATION

The first encounter

I stormed into the antenatal clinic of a tertiary hospital where I was placed for clinical experience as a student midwife. "This will be so easy," I kept telling myself, looking back and forth at the very tired and irritated looks on the faces of the many women sitting in the waiting area. I calmly walked to the nurse's station to introduce myself and explained to the sister in charge my mission and why I was at the antenatal care clinic. The sister smiled and said to me, "Welcome to the real world of nursing". At first, I took these words as sarcasm and could not comprehend what the sister meant. I laughed nonchalantly at her and proceeded to find my follow-up woman. This was not my first attempt at finding a woman but that day I was not prepared to leave without having found someone. I then approached a beautiful, young African woman who was 19 years of age. I asked her to join me in one of the cubicles so that I could talk to her a bit. She obliged but kept on reminding me that she was in the queue and that she did not want to take more of her time to sit and talk. I assured her that I would not take much of her time. I proceeded to tell her that I was a third-year nursing student, and that one of my major assignments required me to follow a woman throughout her pregnancy and deliver her baby.

She immediately got up and yelled that she was only here for a check-up and that she did not have time to waste. My heart sank and I felt so defeated. Sister Nell was right; this was the real world now. No more textbooks to guide you and tell you what to do. There was no correct or clearly defined way to handle this situation. I had to use my own intuition and initiative. Would I ever be able to be assertive enough to find a woman who would be willing to give of her time and personal space to have me embark on this journey with her?

I walked out of the consultation cubicle and it was at that moment that I spotted Gill. She was sitting in a corner at the far end of the waiting area. She smiled at me with so much warmth that I felt an immediate connection with her. I smiled back but was still hesitant to approach her. As with my previous encounters, I gave up the minute the woman said no, with no notion that there was still enough time to find a pregnant woman again. I was so scared of being turned down again. What if she was not interested in having her personal life experience written about? I walked back to the nurses' room and plunged myself into the nearest chair feeling completely defeated. One of the registered midwives saw me and immediately recognised the disheartened look on my face. She sat next to me and shared her first experience, telling me that it sometimes took being knocked down a few times before you could find your feet again. She told me that giving up should not be an option and that I should at least try one more time. I took her advice and went straight to Gill.

She wore a white and yellow floral dress that brought out her complexion so beautifully and ignited her smile when I approached her. I asked her if she would mind talking to me for a few minutes before her name was called and she agreed. After explaining to her my reasons for approaching her and that all she shared would be treated confidentially, she excitedly asked, "So does this mean that you will see me for every check-up and deliver my baby?" I told her that was the plan and that I would be with her every step of the way. She immediately hugged me and said she would be more than happy to have me by her side. She gave me her consent to ask for any information that I would need.

She said that with this being her first pregnancy, she was so scared of facing the experience alone and that having me by her side meant a lot. I was excited and thanked her for trusting me to be part of her experience. She smiled and said, "I have to thank you Taahirah, I am alone in this and having a support person will make my journey so much easier."

Demographic, personal and social data

Gill is a 37-year-old, "coloured", primigravid woman at 24 weeks gestational age. She has an identical twin sister and a younger brother. Being a product of "mixed marriage", Gill admitted that growing up was emotionally draining and challenging, as she was

constantly faced with insults. Gill completed her matric and thereafter, at the age of 19, decided to move to Johannesburg with her twin sister for better opportunities.

Seven years ago Gill met her husband, Ngongane, an African man, who works for a sales company and is able to provide for her. She is currently unemployed as she chose to be a "stay-at-home mum" until the baby is one year old. Her husband supported this option. Gill and Ngongane stay in a one-bedroom flat in Joubert Park. Gill prides herself on being a wife and soon-to-be mother and is grateful that she has a supportive husband. She is seldom alone as her twin sister lives nearby.

Medical history

This was Gill's third antenatal care visit. Her medical history was documented but as this was my first encounter with her, I wanted to make sure that a thorough medical history was obtained. Midwives require a number of skills to achieve optimal antenatal care and, therefore, listening and communication skills are very important. Communication encompasses having accurate and comprehensive records of information and this is what probed me to do my own assessment (Fraser et al. 2009, 242). Apart from being a twin, Gill had no co-morbidities. She did not smoke, and drank alcohol occasionally. I advised her not to drink alcohol during her pregnancy and she responded that drinking was the first thing she stopped when realising that she was pregnant. The main concern of alcohol intake during pregnancy is its teratogenic effect, especially during the second trimester (Cronjé, Cilliers and Pretorius 2011,442), which may lead to, among others, fetal alcohol syndrome (FAS), increased risk of maternal infections, risk of abruption placenta and stillbirths.

Gynecological history

Gill experienced her first menstruation at the age of 14, with a regular cycle. Prior pregnancy, she was using Triphasil contraceptives and she preferred to go back to this option post-delivery. I asked her if she did wanted any more children, and she said she did, but not immediately. I advised her that if she wanted children she needed to consider the fact that she was an elderly primigravida. She gave me a wry smile and said she never thought of that and that she was happy that I advised her. An elderly primigravida is described as a woman who has fallen pregnant for the first time after the age of 35 years, which carries a high risk of maternal and foetal morbidity and mortality. A study conducted by Al-Turki, Abu-Heija and Al-Sibai (2003,1230) revealed that if elderly primigravidas were properly screened and regularly followed up in prenatal clinics, they were found to have limited risks as previously believed, and that elderly primigravidas were at higher risk for complications than younger primigravidas.

Obstetric history

While I was chatting to Gill regarding falling pregnant at such a late age, she said she could not have a baby out of wedlock. She did not want to face the pregnancy alone and was ecstatic to know that she would not. I tried my utmost to be as sensitive when asking questions and constantly reminded her that she did not have to answer anything that she was not comfortable with.

For me, the main concern was the fact that Gill was an elderly primigravida and I needed to make sure of my facts before giving further advice. I asked her if it would be in order for me to take an hour break. She was very understanding and said she did not mind at all. After the break, I went back to Gill and she was delighted to see me again. I informed her that due to the fact that she was 37 years and carrying her first pregnancy, she was prone to certain risk factors, such as gestational hypertension and diabetes. For the first time since my encounter with Gill, her smile faded and she started shifting uncomfortably in her seat. She looked worried and I began to panic that I might have caused her some distress. I calmly explained to her that my purpose was not to scare her but to give her all the information that she would need in order to have a healthy pregnancy. I reassured her that whatever risks we did encounter, the doctors would manage and ensure a healthy pregnancy as far as possible. This seemed to lift Gill's mood slightly. She then seemed more at ease and happier with the information I gave her.

Physical and medical examination

It is important for a midwife to evaluate the physical, psychological and sociological effects of pregnancy in an attempt to provide holistic care. A midwife will achieve this by developing a good partnership with the woman and by exchanging valuable information and advocating for the woman. During every visit, it is imperative to detect complications and manage them accordingly (Fraser et al. 2009, 239).

Gill's booking blood pressure (BP) was 144/96. This was slightly high but no intervention seemed to have been done according to the antenatal card. I would have recommended that she come again in a week's time to ensure that her BP was re-evaluated and also to intervene if it was too high. According to Department of Health grading (2007,78–81), Gill had developed gestational hypertension and was at risk of developing pre-eclampsia as she was an elderly primigravida. The ideal management should be bed rest, a prescription of methyldopa, to be reviewed within 2–3 days or earlier if any danger signs were observed. Her haemoglobin (Hb) was 13.8, which was within normal ranges, she was RH positive (this is the rhesus factor to determine if the mother has anti-D gammaglobulins), and her RPR negative (this is a test to screen for syphilis). Her blood was also drawn for HIV and the rapid test revealed that she was HIV non-reactive. Her first tetanus toxoid injection was given. Antenatal care is the ideal time to provide women with appropriate health education regarding, for example,

diet, rest, exercise, and to screen for conditions that might lead to pregnancy and birth complications (Solarin and Black 2013,359), which I provided. Medications that she received were Pregamal and calcium tablets as iron supplements.

I asked Gill if it were explained to her what these tablets were for, and she said all they told her was that it was for the pregnancy. I was slightly disappointed that this was not properly explained to her but I was also glad at the same time that I also had the opportunity to give her health information. I explained to her that the folic acid would help her baby's neurological development and help prevent illness such as spina bifida. The ferrous sulphate would help to prevent anaemia, which is very common in pregnancy due to all the physiological changes that occur. The calcium tablets would help strengthen both her bone mass and that needed by the baby in order to grow effectively.

Gill was seen by the doctor and she was booked for an ultrasound scan to confirm her gestational age. This was very exciting for both of us and we were in good spirits when going down to the sonar room for the scan. Laughing and giggling, she thanked me once again for being with her. She thought that she was going to face this alone and that I was like her little miracle. I blushed profusely. How could I be someone's miracle? It brought me so much joy that in a matter of a few hours, she already trusted me and was dependent on me.

I asked Gill about any minor ailments she could be experiencing and she reported some backache and heartburn occasionally. Enthusiastic and excited to share my knowledge with her, I explained the causes and management of these ailments to her. I encouraged her to adopt a good posture and appropriate positions, such as bending her knees, when standing and lifting objects. I advised her not to lift any heavy objects, to refrain from wearing high-heel shoes as this could cause her to fall or cause discomfort, and to do pelvic floor control exercises. For heartburn, I advised her on lifestyle modification, which includes a diet high in protein and low in fat, avoidance of coffee, tomato, citrus fruits and alcohol, avoid food 2 to 3 hours before bedtime and to elevate the head of the bed while sleeping (Cronje et al. 2011, 460).

Subsequent visit

I spoke to her the previous evening and we chatted like long-lost friends about to take on an adventure of a lifetime. When I entered the antenatal clinic, I could spot Gill a mile away. Wearing a bright pink dress and the prettiest gold gladiator sandals, she trotted boastfully towards me. I was so excited to have this new friend and I was proud that I could give her support. I always imagined my first pregnancy. The small cosy room, painted white, with my fresh curtains dangling gently by the far corner of the window; my husband right next to me holding my hand while waiting anxiously for the doctor to arrive. Sadly, Gill's life was no movie and she had no husband by her side during antenatal visits. She had to come to the hospital by taxi and waited in a queue for hours.

We went into the examination room and I took her blood pressure, which was 116/63. I gave a sigh of relief. Her urine test showed no abnormalities and her weight was 74.5 kg. She was sure of her dates: 27 weeks' gestational age by dates and 28 weeks by sonar. At this stage of the third trimester, foetal abnormalities may be picked up but the main aim of the scan is to monitor foetal well-being (Fraser et al. 2009, 400). The fundal height was 27 cm and perfectly fitting with the sonar and gestational age. The lie was longitudinal and the presentation breech. The foetal heart rate was vigorous at 154 beats per minute. She was seen by a doctor who confirmed my findings. I asked her how she was finding the advice I had given her. She reported that the pelvic exercises were very helpful in alleviating the back pain and that she still had heartburn but not as frequently or as severe as before.

Gill was now at 28 weeks' gestation, and I felt that it was time for us to discuss her birthing options. I asked her which different options of birthing or labour she was familiar with, and she replied normal delivery and caesarean section. I then explained to her that those were her options here at the hospital and, therefore, advised her to go for normal birth and only if complications arose, such as foetal distress or cephalo-pelvic disproportion, would caesarian section be the most appropriate option as the continuation of labour might lead to foetal or neonatal trauma or even death (Cronjé et al. 2011, 345; Fraser et al. 2009, 570).

She then wanted to know about the process from the time she went into labour. I informed her that the minute she noted any sign of true labour, such as regular contractions lasting 30–40 seconds every 10–20 minutes, and a blood stained jelly-like discharge (show), she should come straight to the hospital admission ward. Midwives would monitor her until the cervix is 3 cm dilated. Then she would be transferred to the labour ward where labour would progress until the cervix was fully dilated and she was ready to give birth. I told her that she would only be allowed one support person according to the hospital policy. She asked if labour was painful. All I said was that every woman's experience was different and for some the pain was unbearable and for others it was bearable enough, to put her at ease. As I had not given birth, I could not possibly comprehend the meaning of such pain. I asked her if she would like to cut her baby's umbilical cord or have her partner do it, as this was an option. She said that she would make that decision closer to the time, depending on how much pain she was in. I then explained to her about caesarean section. She was surprisingly happy about the information that I had shared with her and explained that it was so helpful to have everything explained.

The findings of the next few antenatal visits were more or less similar to the previous ones. The pregnancy was now at the tender mark of 37 weeks. Gill and I discussed her options for feeding after the birth of her baby. Her first choice was breastfeeding and I was delighted that this was her own choice. Human milk is said to be species-specific and has evolved over time to optimise the growth and development of the infant. After

discussing the benefits of breastfeeding with Gill, she was content that she had an ideal feeding plan for her infant (Fraser et al. 2003, 739). Satisfied with the information I gave her, she said goodbye to me.

It's almost here!

Today was a Thursday like no other. I was allocated to a new ward and was running around like a headless chicken. I was trying to orientate myself with this new ward and see to my allocated patients before I had to meet up with Gill. I promised to meet her at 08:30 that morning, and when I looked at my watch again it was almost 10:00. My heart almost stopped when I received a frantic call from her saying that the nurses said her blood pressure (BP) was too high and they put her on the bed to rest a bit before the BP was repeated. She also said that she had not felt her baby kick since the previous morning and she was very worried. In a panic, I rushed down to the clinic.

My mind was racing and I was praying frantically, "Please dear God, do not take this little blessing from her. She is 37 years old; what if she cannot fall pregnant again? This is her only chance and she has got so far in her pregnancy already." I paused outside the clinic to compose myself. I kept telling myself that I needed to focus on Gill and be there for her as a pillar of strength.

I pulled myself together and dragged my feet through the entrance door. My heart sank as I walked towards the examination cubicle. Was Gill alright? I saw her as I entered – lying on the bed and still beaming with a smile on her face, she greeted me. She said that all was in God's hands now and she would accept whatever was coming her way. I could not comprehend this woman's strength. She might lose her child and yet her faith was still unwavering! I never realised how much I had taken for granted in my life until that moment. A life lesson I would never forget. I told her that it was possible that the baby was resting and that the baby must have moved when she was distracted by something else or as a result of the high blood pressure that leads to placental insufficiency (Cronjé et al. 2011, 539).

I could not help but notice that her radiant smile was no more and a tired and frustrated look resided on her beautiful face. I took her in an embrace and reassured her that she was going to be fine. Her baby was due in two weeks and she needed to take things easy. We agreed to meet the following week and I advised her that if she felt dizzy, had headaches or started experiencing blurred vision, which could be the signs of pre-eclampsia, that she call me immediately and come to the hospital.

I phoned Gill almost every day that week just to make sure that she was alright. As I was making my way to the clinic later that morning, I met Gill in the corridors of the hospital. Gill and I, catching up as usual, made our way to the clinic. She said that she was beginning to feel pain, although not regular, and the pain was uncomfortable. I explained to her that in the last few weeks before delivery, Braxton Hicks contractions occur as false contractions. I asked how our little gymnast was this morning and she

said, “See for yourself”. I placed a hand over her perfectly round tummy as we paused for a bit. This little girl was bouncing back and forth. I could not help but feel refreshed at the thought that pretty soon we would be ogling over this little piece of wonder. After testing her urine and monitoring her weight, which was now a surprising 84 kg, we made our way to the examination cubicle. I realised that she had gained 23 kg during her pregnancy and that the baby was large for gestational age as the height of fundus measured 40 cm and she was 38 weeks by dates. This might also imply that Gill was not sure of her dates.

Gill was seen by the doctor and she seemed very concerned. A bit confused as the doctor did not give her a chance to ask anything, I asked her if she was fine. Uncertainly, she looked to me for advice. I knew that this was not her birthing plan of choice and a worried frown creased over her face. She said that she was confused, “Does this mean I’m having a baby today?” I apologised frantically for the doctor not explaining things clearly to her. I went on to explain that the doctor was worried that the baby was too big and that she would not be able to deliver naturally and that was the reason for the scan. My view was that the doctor should have explained the situation to her as she had the right to information involving her pregnancy management. I told her that since it was so close to her due date, it was safe to induce labour as recommended by the doctor as the baby’s lungs were mature already and no problems were foreseen. The benefit of the induction was to avoid possible prolonged labour and caesarian section due to macrosomia (Fraser et al. 2009, 520). This seemed to ease Gill and she immediately got onto the phone to inform her husband. Her bags were already packed and she wanted her husband to be with her as well. She then called her mom and tears rolled gently down her slightly swollen face. Gill’s parents had planned to come through that weekend to be with her and Ngongane. I knew that I could never be able to fill that loneliness for not having her mother by her side.

We immediately went for the sonar. I was supposed to be at work that morning but explained to the sister in charge that I was attending to Gill. I wanted to run up to the ward just to show my face but she begged me not to leave her alone until her husband arrived, and I stayed by her side.

We entered the cold, tattered, and run-down ultrasound room. The room was dimly lit and the sonographers looked withered and frustrated. I politely smiled to one sonographer and explained that the doctor needed to urgently see if this baby was big enough to book her for caesarian section. I purposefully exaggerated the issue to the sonographer so that I could speed up the process of getting Gill admitted. I offered my broadest and most polite smile and thankfully she obliged. I was overjoyed that I had succeeded.

Immediately, the sonographer took Gill to the bed. I was hoping that the little one was looking forward to being delivered naturally. The estimated foetal weight was a surprising 3.7 kg. According to the sonar, the foetal head was engaged. Gill was not yet past her expected date of delivery but the baby was diagnosed as large for gestational

age. This implied that Gill was to deliver through a caesarian section. Despite the baby being large for gestation, Fraser et al. (2009,569) also highlight that a first pregnancy at the maternal age of 34 commonly needs a caesarian section.

I do not know if I was disappointed because I was not going to deliver her baby naturally or because of the fact that I did not want her to go through that pain and agony, especially since it was her first baby. Secretly I knew that it was a mixture of both. I did not want to startle her anymore and so I pretended that it was the best option. I explained to her that if she had been induced, the process would have been very tedious and tiring. I explained that it would take sometimes up to 24 hours before cervical dilatation occurs and that the pain could sometimes be unbearable as the misoprostol causes hypertonic contractions. This seemed to make her more at ease with the prospect of facing surgery.

We then proceeded to the Cardiotocography (CTG) room where I put her on the CTG machine to get a good tracing of the foetal heart. Ngongane had arrived with Gill's bags and I finally met the man I knew so well from Gill's stories. A tall and slender man, he approached me with the look of a man who had just won the lottery. He shook my hand in a tight and firm hold. His palms were sweaty and he looked excited and anxious at the same time. I had told Gill that she should tell him to bring her something to eat as we did not know what time her delivery would be and I thought that it would only happen later as it was not an acute emergency. I let Ngongane join her in the room and gave them some time alone. This also gave me some time to go back to my ward and show my face to the sister. After all, I still needed my time sheet to be signed.

When I returned twenty minutes later, the non-stress test was put on to monitor the foetal heart. The heart rate was excellent between 120 to 150 beats per minute. No evidence of deceleration was noted and good foetal movement was recorded.

A new world awaits

By the time I gathered her bags and helped Gill to make her way to the maternity admissions ward, I could see the frustration on her face. I could only but imagine the fear that was radiating through her entire being. Surgery was a big deal for anyone. I clasped her shaking hand gently and gave her a reassuring smile. She knew that I was here for her every step of the way.

As we entered the labour ward, we were welcomed by the bubbly and vibrant chants of Sister Lindi's voice giving a warm welcome to all the soon-to-be mothers. The atmosphere felt light and I could feel Gill beginning to relax as I continued to hold her hand. I gathered her file, booked her in and then proceeded to admit her in the register at the front desk. When I returned, I saw that there were 10 women before her who had to be attended to. Ngongane was by her side, so I knew that I could slip away for lunch and just rest a bit before we headed for the stretch. She kept thanking me for not leaving her side and said that I should not hurry from my lunch as she trusted that she was now in good hands.

15:00 – The clock keeps ticking

On my return, I found Gill already prepared for surgery. I had to go back to my ward and see to my patients and do the final routine before I could officially leave my workplace and give my undivided attention to her. I said a little prayer for her and asked God to bless her and give her so much happiness through this new arrival.

17:30 – Snip-snip-snip: It is finally time!

After hours of waiting and chatting, Sister Lindi finally peeped through the curtain of Gill's cubicle and informed us that the theatre was ready. Ngongane looked anxious and I reassured him that all would be alright. I handed Gill over to theatre staff and then headed off to change into theatre clothes. I was going to be a "catch" sister and the thought sent jolts of excitement through my system. This was almost the end of our journey together. At a moment where I should be at my happiest, I suddenly found myself sad.

I made my way to the theatre. Gill was already on the table, covered in green sterile cloths. Gill was given the epidural and her abdomen was cleansed with a sterile betadine solution. I kept looking back and forth at her and gave her every reassuring smile that I could muster. I had to make her feel as comfortable as possible. Our baby was ready to make her grand entrance.

18:00 – Finally!

The room suddenly went still as if time had stopped. Nothing except the wailing screams of our new arrival pierced the silence. I dashed with stumbling steps towards the doctor who yelled, "Time of delivery, 18:15". He handed me the baby and I excitedly carried our bundle of joy to Gill. I opened the green cloth to show her the sex of the baby and have a good look at her little baby's face. I have never seen a smile that could lit up a room like Gill's. Her voice was quivering to hold back the tears that had surfaced and all she could manage was a whisper, "Welcome my princess". I then proceeded to the next room where I helped the sister clean baby Gill and, and get her all warm and comfortable. She stopped wailing with screams of protests as her mouth found her tiny thumb and she began to suck. The sister and I then proceeded to do the baby's head-to-toe examination.

Gill's abdomen was sutured up and she was transferred to the recovery area. I brought her baby to her and encouraged her to begin her first feed. Tired and weary, she smiled at me and accepted her little bundle. I could see that she was beginning to feel the pain. I waited a while for her to relax and get comfortable before I helped her to breastfeed.

Time to move

Both tired and drained by this long day, I made my way with Gill to the postnatal ward. We met Ngongane in the labour ward corridors. He asked to hold the baby as we made our way side by side to the lifts. He was the proudest father in the hospital. Ngongane bid us farewell at the postnatal ward. I then moved Gill onto the postnatal bed and the sister assisted me to monitor her postnatal vital signs. After ensuring Gill and the baby's comfort, I left. Gill, who was exhausted from the day's event, bid me a very tired but truly grateful goodbye.

At 10:00 the next morning I walked into the ward. Gill sat on the far end of the corner with her eyes glued to the baby. I was so happy to see her alert. I ran over the postnatal examination for both, and informed her about the immunisation for her baby. I could not stay long as I had classes to attend. I was saddened that I could not be with her before she was discharged that evening at 20:00. I gave her a call to find out how she was and she indicated that all was well.

Home visit

I visited on day two post-delivery. Gill stayed in a small flat that was very cosy for a family of three. Ngongane was at work. She was delighted to see me again, overwhelmed with emotions. We chatted over a cup of tea and I thanked her for the opportunity she gave me to share this life-changing experience. She also thanked me for the support. I gave both mother and baby some gifts and then I departed.

ETHICAL CONSIDERATIONS

Voluntary participation was ensured throughout the study. Beneficence was maintained by preventing any harm to both woman and baby. Permission was obtained from the woman to conduct and publish the study. Pseudonyms were used to maintain anonymity and no institution name was reflected in the report, although the study would cause no harm to the institution.

DISCUSSION OF FINDINGS

Narrative analysis

The analysis aimed at sharing the truth about the student's experience through her own interpretation of the event (Druckman 2005,7). The narrative analysis of the student's experience revealed several themes that reflected holistic care, ethical considerations and values as displayed by the student. Holistic nursing is practised by nurses virtually in every area of care. The speciality, as stated by Dossey and Kegan (2013,20), with reference to the American Holistic Nursing Association (AHNA), is based on a practice

that recognises the body-mind spirit connection of individuals and demands that practitioners integrate self-care and self-responsibility into their own lives. Holistic care is thus evidenced in the interventions the student undertook in her interaction with the woman, which addressed the woman's physical, psychosocial and emotional needs related to her pregnancy, as shared throughout her story-telling. The ethical principles and themes that emerged from this case study are autonomy, beneficence, veracity, confidentiality, humility, responsibility, empowerment and courage. The stated principles will be discussed within the context of this case study.

Ethical principles

Adherence to the following ethical principles emerged from the student's narrative analysis, which reflected the importance of respecting the woman's wishes and decisions.

Autonomous decision-making

The concept of autonomy requires individuals with capacity to be treated with respect as autonomous beings. On the first encounter, the student midwife informed the woman regarding the purpose of the project she is undertaking and that the woman should voluntarily agree to participation as reflected in the following statement. After explaining to her the reasons I approached her, she excitedly asked, "So does this mean you will see me for every check-up and deliver my baby?" As stated by Bristol and Hicks (2014,18), autonomous participants have the right to hold views, make choices and take action based on personal values and beliefs.

Beneficence

The care that the student offered to Gill was aimed at doing well for the well-being of the mother and baby by offering physical, psychological, social and spiritual support. Beneficence, in the context of this study, offered Gill, as a participant, additional attention and knowledge that any other woman might not have received (Frith and Draper 2004,254) and the "best option" of care under the given circumstances was an act of kindness at all times (SANC 2013,4).

Veracity

The health information that the student shared with the woman was true and in the best interest of Gill, and had literature references, for example, "I told Gill that heartburn is caused by the pressure of the enlarging uterus on the stomach … and thus result in stomach acid being refluxed into the oesophogus" (Fraser et al. 2009, 188).

Justice

The student pursued justice and demonstrated an ability to advocate for the woman as stated in the SANC (2013,4) Code of Ethics, for example, "I politely smiled to one sonographer and explained that the doctor needed to urgently see if this baby was big enough to book her for caesarian section. I purposefully exaggerated the issue to the sonographer so that I could speed up the process ..."

Humility

Humility is a way to respect others who may have attitudes and beliefs that differ from your own. It is the ability to recognise that one is fallible, modest about own beliefs and is willing to learn from others (Baughman, Aultman, Ludwick and O'Neil 2014,56). Humility was reflected throughout the student's acknowledgement of the woman's responses as follows: "She said that all was in God's hands now and she would accept whatever must come her way. I could not comprehend this woman's strength. She might lose her child and yet her faith was still unwavering."

Confidentiality

Maintenance of confidentiality was reflected in the following statement, "and that all that she shared with me would be held in strict confidence".

Challenges and opportunities

The following aspects highlight the challenges and opportunities experienced both by the student and the woman.

Courage

Courage, a mental or moral strength to venture, persevere and withstand fear and difficulty, was displayed after the student's first encounter with the initial woman with whom she did not succeed: "She immediately got up and yelled that she was only here for check-up and that she does not have valuable time to waste. My heart sank and I felt so defeated. Sister Nell was right; this was the real world now."

Responsibility

The student made it her responsibility to ensure the mother and baby's well-being by accepting to be the woman's partner and keeping the communication lines open for any advice that the woman might need. "I advised her how to monitor foetal well-being at home and to report if the baby is not kicking and that if she felt dizzy, had headaches

or started experiencing any blurred vision, that she called me immediately and come to the hospital."

Empowerment

Empowerment was displayed by ensuring that Gill had access to information and resources needed to make informed choices about her health.

Support

There was an indication of the need for support by the woman as she indicated that, with this being her first pregnancy, she was so scared of facing this experience alone. She smiled and replied: "I have to thank you, Taahirah, I am alone in this and having a support person will make my journey so much easier."

Fulfilment

There was a sense of fulfillment from the experience on the part of the student as shared through the following: "This was surely the best experience that I have ever encountered in my life .... This became more than an assignment. This was a life lesson, one I don't ever intend on forgetting."

A study conducted within the same context by Modiba (2013,115), focusing on the women's experiences of a follow-up child-bearing journey, led to the findings that women experienced that student midwives were genuinely interested in the interaction, and felt that caring was addressed adequately and holistically, and as such promoted women's confidence in managing their pregnancies.

Health information opportunities

Constant willingness to share health information was reflected by, for example: "I was so excited to finally be able to give her sound advice, and Gill wanted to know what she should bring and what happens from the time she goes into labour. All I said was that every woman's experience is different and that for some pain was unbearable and for others it was bearable."

The right to reproductive health

The woman's right of access to reproductive health care was offered to Gill as stipulated in the Constitution of South Africa (Bill of Rights, Chapter 2, section 27 1(a)). The student used her professional skills positively and proactively to empower the woman to achieve her right to reproductive healthcare as stated by London and Baldwin-Ragaven (2008,15) as she acted as her advocate throughout the whole interaction.

CONCLUSION

The case study allowed for a systematic observation of the student's own and the woman's experiences, and inner subjective processes of the lived experiences. The student midwife reflected the ethical principles and a holistic approach in the care she offered to the woman. Frisch (2001,2) states that a holistic nurse is an instrument of healing and a facilitator in the healing process and that holistic nurses honour the individual's subjective experience about health beliefs and values. Furthermore, in being a therapeutic partner with individuals, a holistic nurse draws on nursing knowledge, theories, research, expertise, intuition and creativity, a principle that was displayed within the student-woman interaction.

Holistic care was displayed through the provision of physical care, psychosocial and spiritual care. There is an indication of the exchange of knowledge, love, sharing sorrow and pain and letting the woman express her feelings. The student assisted the woman to gain self-knowledge, self-caring and self-control regardless of the unfamiliar environment. The student was a co-participant as reflected by transpersonal and metaphysical human to human interaction and connection. The roles that were fulfilled by the student midwife are those of a clinician, a scholar, a scientist, a moral agent and a humanitarian (Watson 2012,66). The findings are consistent with a conscious act that conveys a will and an intention to care. The right of the woman to access reproductive health was offered based on the Bill of Rights in the Constitution of South Africa. The case study offered the student a learning opportunity as she referred to literature to justify her information, for example, on reflecting on an elderly primigravida.

As stated by Watson (2012,10), caring is aimed at preserving humanity and the concept of an inner person's life world, and reintroducing love and healing into educational and clinical practice. Human caring begins with oneself and radiates to the recipients of care, and as such, the midwife needs to display characteristics of inner caring (eco-caring) to be able to offer optimal care to a pregnant family, which the student fulfilled.

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This assignment is dedicated to two of the strongest women I know. Gill my follow-up woman and my dear mother. I never realised the courage it takes to bring a child into this world, and this experience has taught me that love has no bounds and that we all have a strength within us that is guided by God and the good faith. I thank Gill for all that she has taught me, her unwavering faith and her strength that showed no defeat. You will always remain in my heart.

To my little Qaunita, you were an angel at birth, a breathtaking sight! May you forever remain the apple of your father's eye and the coolness of your mother's heart.

REFERENCES

Al-Turki, H. A., A. T. Abu-Heija, and M. H. Al-Sibai. 2003. "The Outcomes of Pregnancy in the Elderly Primigravidas." *Saudi Medical Journal* 24 (11): 1230–33.

Bristol, S. T., and R. W. Hicks. 2014. "Protecting Boundaries of Consenting Clinical Research: Implications for Improvement." *An International Journal for Health Care Professionals* 21 (1): 16–27.

Baughman, K. R., J. M. Aultman, R. Ludwick, and A. O'Neil. 2014. "Narrative Analysis of the Ethics in Providing Advance Care Planning." *An International Journal for Health Care Professionals* 21 (1): 53–63.

Cox, K. 2001. "Stories as Case Knowledge: Case Knowledge as Stories. *Medical Education* 35 (9): 862–866.

Cronjé, H. S., J. B. F. Cilliers, and M. S. Pretorius. 2011. *Clinical Obstetrics. A South African Perspective.* Third edition. Pretoria: Van Schaik Publishers.

Department of Health. 2007. "Guidelines for Maternity Care in South Africa." *A Manual for Clinics, Community Health Centres and District Hospitals.* 3rd ed. Pretoria: Republic of South Africa.

De Vos, A. S., H. Strydom, C. B. Fouche, and C. S. L. Delport. 2009. *Research at Grass Roots for the Social Sciences and Human Service Professions*. 3rd ed. Pretoria: Van Schaik.

Dossey, B. M., and I. Keegan. 2013. *Holistic Nursing – A Handbook for Practice.* 6th ed. Burlington, MA: Jones & Barlett Learning.

Dragonas, T., and G. N. Christodoulou. 1998. "Prenatal Care." *Clinical Psychology Review* 18 (2): 127–142. doi:P11 SO272-7358(97)00085-8

Druckman, D. 2005. *Narrative Analysis.* Thousand Oaks, California: SAGE Publications.

Fraser, D. M., M. A. Cooper, and A. G. W. Nolte. 2009. *Myles Textbook for Midwives.* African Edition. Edinburgh: Elsevier.

Frith, L., and H. Draper. 2004. *Ethics and Midwifery*. B*f*M *Books for Midwives*. 2nd ed. Edinburgh: Elsevier.

London, M. D., and M. D. Baldwin-Ragaven. 2008. "Human Rights and Health: Challenges for Training Nurses in South Africa." *Curationis* :5–18.

Mitchell, M., and M. Egudo. 2003. "A Review of Narrative Methodology." DSTO System Sciences Laboratory. Australian Government Department of Defence. Defence Science and Technology Organisation:1–50.

Modiba, L. M. 2013. "Women's Experiences of a Follow up Childbearing Journey with Bachelor of Science Students in Gauteng Province, South Africa." *African Journal for Physical Health Education, Recreation and Dance*, Supplement 1:108–116.

Republic of South Africa. 1996. *The Constitution of South Africa.*

Rodríguez, C., C. A. des Riviéres-Pigeon. 2007. "Literature Review on Integrated Perinatal Care." *International Journal of Integrated Care* 7:1–13.

Royal College of Nursing (RCN). 1998. "Conducting a Narrative Analysis." *Collegian* 5 (3): 34–36.

Solarin, J., and V. Black. 2013. "'They Told Me Not to Come Back'. Women's Antenatal Care Booking Experience in Inner City of Johannesburg." *Maternal Child Health Journal* 17 (2): 359–367.

Sumner, J. 2001. "Caring in Nursing: A Different Interpretation." *Journal of Advanced Nursing* 35 (6): 926– 932.

The South African Nursing Council (SANC). 2013. Code of Ethics for Nursing Practitioners in South Africa. Excellence in Professionalism and Advocacy for Healthcare users. Pretoria: SANC.

Tjale, A. A. 2007. "Holistic Nursing Care: A Concept Analysis. PhD thesis, University of the Witwatersrand, Johannesburg, South Africa.

Watson, J. 2012. *Human Caring Science. A Theory of Nursing.* 2nd ed. Canada: Jones & Bartlett Learning.