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# Midwifery Students' Perception of Intimate Touch in Clinical Practice

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Additional information is available at the end of the chapter

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## 1. Introduction

The term 'intimacy' and 'intimate' from the Latin words *intimus* (innermost) and *intimare* (to make the innermost known) can be used to refer to feelings, to verbal and nonverbal communication processes, to behaviours, to people's arrangements in space, to personality traits, to sexual activities, and to kinds of long-term relationships [1].

In midwifery, touch has many purposes, meanings, and enactments. Some forms of touch do not cross the boundaries of the culturally accepted, while on some occasions, intimate physical touch must be employed in order to provide necessary care. Such touch involves inspection of, and possible physical contact with, those parts of the body whose exposure can cause embarrassment to either the woman, her partner, or the midwife.

Midwifery students who are still in the process of learning may be seen as a special and vulnerable population because in clinical settings, they might feel as outsiders, left alone to tend to their own learning needs, inexperienced in midwifery care, and unsure of their rights; alongside, as young people, they are often still struggling with their own sexual identity, orientation, and sexuality in general. At the same time, it is expected that as midwifery students in clinical practice, they will maintain clear sexual boundaries at all times towards the people for whom they provide care.

## 2. Literature review

Intimacy usually occurs between two people who influence each other's feelings and behaviour [1]. Pregnancy and childbirth have the potential for being intimate and emotionally charged

experiences for all involved [2]. The model of intimacy as shown in Figure 1 shows the comprehensive conceptualization of intimacy that encompasses individual, interactional and relationship qualities [3].

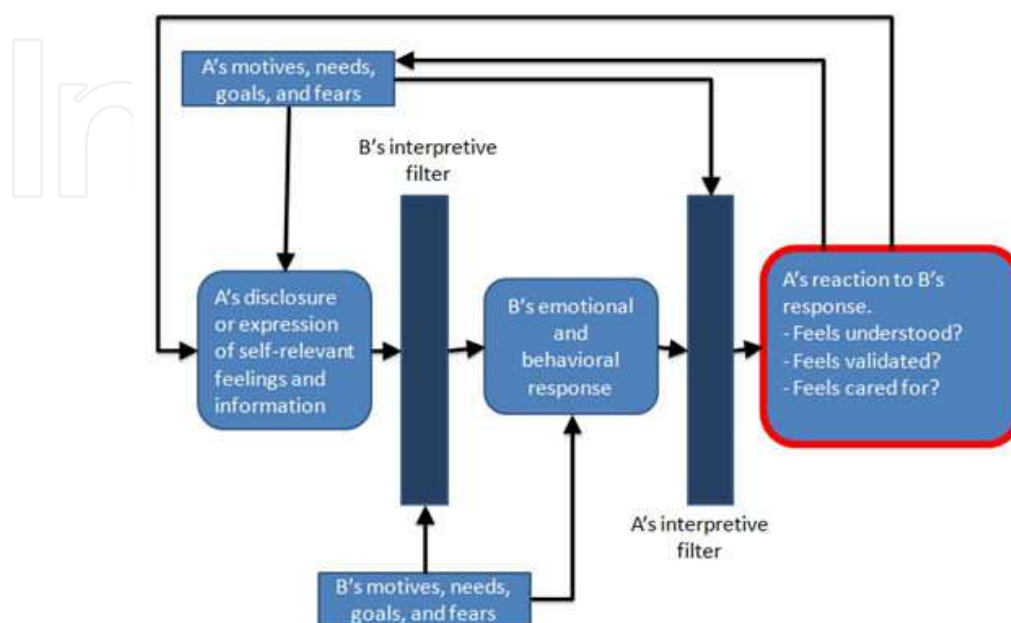


Figure 1. The model of intimacy [1]

The majority of midwifery work involves intimate knowledge of another's body, which normally includes physical contact. Nevertheless, according to [2], contemporary midwifery work is much broader and has several key features:

- Changes in the organization of care, with an emphasis on continuity and the potential increase in the emotional aspect of work. Midwives often work in situations where there is a high level of expressed emotion. Midwifery work is intimate and involves acknowledgement of sexuality.
- Midwives often work with women who are experiencing intense pain. The division of labour within maternity care results in additional emotion management.

In the literature, various terms have been used to describe intimate touch. Intimate physical touch is defined as involving 'inspection of, and possible physical contact with those parts of the body whose exposure can cause embarrassment to either the patient or the midwife' [4]. O' Lynn and Krautscheid [5] went into details and defined intimate touch as oriented touch to areas of a patient's body – genitalia, buttocks, perineum, inner thighs, lower abdomen and breasts, as well as other areas, depending upon the patient, nurse or midwife, that may produce feelings of discomfort, anxiety or fear. Women, during pregnancy, birth and postpartum, are often compelled in situations when several different health professionals, consciously or unawares, invade their intimate and personal sphere. Procedures like vaginal and rectal

examinations, pubic shaving, enemas and breast palpations that are part of midwifery care can be a brutal invasion in a woman's personal and intimate space if not performed tactfully.

Midwives are dealing with healthy women experiencing a normal life event, but there is evidence from the literature that, for some women at least, giving birth is a sexual experience. All clinical settings, especially the labour ward, are an important and challenging learning area for midwifery students because it is where the students learn in authentic complex situations and in intimate situations [6]. It is crucial to realize that health care professionals need to restore the sense of meaning and stop sleep walking through the professional world. They need to recognize that there is a choice of how to behave and choose excellence over ambivalence in every interaction [7].

Many midwifery students enter midwifery with a sense of awe and wonder, searching for meaning in their lives. Every one of them needs to be encouraged to engage with the powerful search for sense of meaning which brought them to midwifery study [7]. Midwifery practice is an integral part of midwifery education, in which clinical mentors play an important role. Mentors' attitudes, experience and knowledge are influences [8]. Therefore, midwives need to stop sleepwalking through their professional life, wake up and recognize that within every interaction, there is a choice of how to behave and an option to choose excellence over ambivalence [7]. The fact is that clinical mentors influence student midwives while they are on clinical practice and that quality care is more than a set of processes. As Nettleton and Brail [9] pointed out, considerable attention has been given to the benefits of mentorship, but equally, poor mentorship can bring long-lasting consequences for those being mentored. Students who are generally novices in age, social maturity and social responsibility struggle to take on the professional responsibility of providing intimate care to strangers [10]. As Walker and Davis [11] found out, the role of mentors who teach and work with midwifery students on the topic of sexual health is very important, as they help them give confidence when working in this area.

### 3. Methodology

In this chapter, the study aim and the research question are presented. The research methodologies, specifically qualitative methodology and grounded theory, are described and discussed. This chapter also discusses the methods of study used to investigate the research question. The main ethical considerations are discussed. A description of the selection of participants is provided, and a discussion of the data collection follows. Finally, a summary is presented about the process of data collection, management and analysis.

#### 3.1. Study aim

The process of this research started with identification of the research problem and consequently forming the research question that demarcates the phenomenon to be studied. The primary focus of this research and at the same time the research question of this study therefore is: What are midwifery students' perceptions of intimate touch in clinical practice?

- The aim of this study is To explore the concepts of midwifery students' perception and experience of intimacy To capture the students' most typical experiences of intimate touch in clinical practice

### 3.2. Qualitative methodology

Qualitative methodology guided this research study and therefore formed the basis for the research procedures and strategies. The main attraction of this perspective is that it is person centred and holistic, and, as Rees [12] describes, it concentrates on an individual's perceptions, experiences and personal insights. Furthermore, it attempts to encourage people to express their perceptions of situations or feelings in their own words [12].

### 3.3. The grounded theory approach

For the purpose of this study, it seemed the most appropriate to adopt the grounded theory approach to close the gap in knowledge about the midwifery student's perception on intimate touch in clinical practice. According to Straus and Corbin [13], grounded theory is a creative process that facilitates the development of a new theory and therefore is an appropriate approach to use when there is a lack of knowledge about a topic. Understanding how midwifery students interact and the factors that influence their behaviour is an important aspect of midwifery care. Furthermore, as Hall et al. [14] pointed out, grounded theory is ideal for capturing the complexity of midwives' and midwifery students' therapeutic exchanges with expectant mothers.

Grounded theory was originally developed by Glaser and Strauss in the 1960s, and it means to make possible the 'systematic discovery of theory from the data of social research' [15]. Strauss and Corbin [13] showed that the purpose of using a grounded theory approach is to develop a theory about phenomena of interest that is faithful to, and illuminates, the area under study.

As Morse [16] pointed out, grounded theory is an important qualitative method which makes major contributions to nursing and therefore also midwifery research. This method offers a systematic approach through the clarification of varied responses and therefore focuses on the social meaning people attach to the world around them.

In grounded theory, the researcher drives a general, abstract theory of a process, action or interaction grounded in the views of participants [17]; therefore, it is important to understand, as also Douglas [18] pointed out, that grounded theory acknowledges the role of the researcher as part of the research but also demands from the researcher to interfere as minimally as possible.

### 3.4. Ethical considerations

Every aspect of this research study was guided by ethical research standards which are informed consent, confidentiality and anonymity, voluntary participation and the right to withdraw [19].

#### *3.4.1. Informed consent and voluntary participation*

In the current study, prior to informed consent being obtained, verbal and written explanations were given to participants regarding the study. This was done when the researchers presented the study to the potential participants. The researchers spoke about the purpose of the study, the procedures and the conditions of consent as well as answered questions. The researchers also spoke about how confidentiality or anonymity for the participant will be ensured. The information sheet was given after the presentation to all students that attended the presentation. Those that showed interest in participating were given a gap of 48 hours between receiving the information and consenting. Two days after the presentation, the researcher got in touch (personally) with the interested participants to find out if they had decided to participate in the study. All 13 students who decided that they wished to participate were given a consent form to sign.

Informed consent is important, as it allows participants to make an informed and voluntary choice to participate or refuse to participate [20]. As Holloway [21] pointed out, the process of informed consent is based firmly within the principle of respect for autonomy and means that participation is voluntary. The participants were made clear that the consent in qualitative research, as Holloway and Wheeler [22] pointed out, is an ongoing process and if they decided to withdraw their consent at any stage during the study, either before or during the interviews, they were free to do so. It was clearly expressed in the written and verbal details that no reason or explanations were required if participants chose to withdraw from the study. However, none of the participants withdrew from participating in the study.

#### *3.4.2. Anonymity and confidentiality*

Bluff (2004) [23] points out that ethical issues of anonymity and confidentiality are somewhat unique with grounded theory research, especially when the sample size is small, as in the current study. Furthermore, as Cheek [24] stressed, when the research is conducted in a specific setting, among a specified group of people, as in the case of the current study, anonymity might be difficult to ensure. The researchers therefore paid special attention to protect the anonymity and confidentiality of the participants. To protect anonymity of the participants, pseudonyms were used throughout the research process and in the final report of the study. Assurances were given to participants by the researchers that any information gained during the interview would be held in the strictest confidence. In addition, the researchers guaranteed the anonymity of participants in any reports or publications generated as a result of this study.

Confidentiality between the participants and the researchers was assured by meeting the participants in a safe environment. The time of the interviews was always scheduled to suit the participants. All data were dated and labelled with pseudonyms to avoid identification of participants or in the event of loss or theft. The data were kept in a password-protected computer, and all tapes and written notes generated were placed in a locked cabinet, the key being held by the researchers.

### **3.5. Data collection, management and analysis**

The aim of this research study was discovering a phenomenon in a social context; therefore, to gather rich data in order to generate a strong grounded theory, unstructured interviews



were found as the most appropriate data collection technique, as it permits exploration of how midwifery students perceive intimate touch in clinical practice. The inclusion criteria for the participants were the following: third year midwifery student at the University of Ljubljana and Faculty of Health Sciences who finished all clinical practice. Each participant was a volunteer. McNamara [25] points out that interviews are particularly useful for getting the story behind a participant's experiences and that the interviewer can pursue in-depth information around the topic. Face-to-face interviews were conducted over the period of 2 months that consisted of nine in-depth and open-ended questions. The interviews lasted from 15 to 25 minutes and were audio taped from the beginning till the end. The tapes were labelled using the participants' pseudonyms. After the interview, researchers relistened to the recorded conversations, and the interviews were transcribed as verbatim as possible.

In grounded theory (as described by Liehr and LoBiondo – Wood) [26], data analysis proceeds through several levels and comprises several distinctive features which assist the research process. They are theoretical sensitivity, theoretical sampling and saturation, coding and categorizing the data and theoretical memos.

As Bluff [23] describes, the sample size in a grounded theory study tends to be small. According to Straus and Corbin [13], the key to grounded theory is to generate enough in-depth data that can illuminate patterns, concepts, categories, properties and dimensions of the given phenomena. Theoretical saturation occurs when no new or relevant data seem to emerge regarding a category, and, as Strauss and Corbin [13] pointed out, the category is well developed in terms of its properties and dimensions, demonstrating variation and the relationship among categories, which are well established and validated. In the current study, the saturation occurred with the sample size of nine participants. Data collection and analysis were ongoing throughout the research and involved three steps: open coding to find categories, axial coding to find links between the themes/categories and selective coding to find the core category which explained the phenomenon that was emerging from the study.

#### 4. Findings and discussion

This chapter is providing an overview of the findings that gave rise to the theory. The properties and dimensions of the core category emerged slowly. The core category **Feeling abused and being the abuser** allowed the researchers to refine a conceptual theory to explain all the categories and their interrelationships.

The three categories relate to the core category, which is the central phenomenon and, at the same time, the main concern of third year midwifery students in Slovenia. The core category **Feeling abused and being the abuser** is broad in range and is able to integrate and explain the relationship between the key categories. Because of the unprofessional attitude towards women and students and between clinical mentors, many boundaries are being crossed, and as a consequence, the quality of being worthy of respect of all involved is being compromised.

*If a woman doesn't allow for students to be present (pause), well, I think she has a reason for it and I am not going to that room! But then the clinical mentor forces you to go in saying "put your badge to*



**Figure 2.** The core category, the three conceptual categories and their concepts

*your pocket and go, the women won't even know that you are a student!" and that makes it even worse. At that point (pause) just checking the uterus (pause) it's hard... you have a feeling that you are violating her (pause) with your presence, with your hypocrisy doing something the mentor told you to do. (Lila)*

Midwives are supposed to be supportive, empathic and acting as advocates for women. The environment in which they are working should be such that the midwife is, as Field [27] stresses, able to expect the support and empathy from colleagues. This is even more important when a midwife is also a mentor to midwifery students who are sent to clinical practice. The desirable mentor qualities, as pointed out by NHS [28], are – among other qualities, personal characteristics and behaviours – acting as a role model, awareness of own practice and positive attitude towards students. *It was in the first year when we had clinical practice in the delivery room, I was assigned to work with an older midwife, and she was also my clinical mentor. She told me nothing, she kept leaving me alone in the room. When I asked her something she answered in a rude manner. I was on my own, scared and I remember I was forced (by that mentor) to give an enema to a woman who didn't want it. (Zarja)*



**Figure 3.** The circle of the key categories



The above-mentioned categories rounds around and define the core category. Unprofessional attitude, boundaries being crossed and broken dignity were found to have a central consequence, which is the statement that midwifery students at clinical practice, when they are dealing with intimacy/intimate touch, are feeling abused and, at the same time, feel that they are the abusers. The theory is true to real life, as it explains how midwifery students perceive their experience of intimacy in clinical practice and what is their most typical experience of intimate touch in clinical practice and is clearly understandable to participants, educators and health care professionals.

#### 4.1. Unprofessional attitude

The category **Unprofessional attitude** considers the importance of informed consent, the seriousness of communication failures, the fact of lost assertiveness and the presence of fatigue and apathy.

Every medical examination might be considered as an intimate event. Assessing the location of the fundus of the uterus can be just as intimate as examining the eye. Therefore, all procedures in health care need to be based on informed consent. Intimate examination and all sources of treatments can be a source of distress and discomfort to women. It is crucial that midwives and midwifery students are well aware that a competent adult has a right to respect for his autonomy, which includes protection of his bodily integrity. The patient's right to autonomy should always be respected, and steps need to be taken to make consent truly informed [29]. *No, I am not asking for real...I don't think I am asking for real...I explain what we are going to do, and how it is going to be done, sometimes even why....in matter of fact if a women doesn't answer to my explanation I take her silence as a consent... (Jona)*

Students aim to respect their patient's wishes and preferences, though when the patient's preference cannot be maintained, they provide intimate care as an essential activity of daily living [30]. However, this could be counterproductive, as the midwives' fitness to practice could be challenged when providing care without full consent [31]. A principal general practitioner wrote her personal experience of intimate examination, emphasizing how the informed consent failed to protect her. She described her experience: 'I was admitted to hospital. Preoperatively, 12-20 people in white came to examine me. I did not realize, but medical students could examine patients unsupervised, as I assumed they were doctors. They all performed chest and abdominal examinations. Three performed breast examination. All performed vaginal or rectal examinations. Three performed both, which was particularly distressing. Consent was obtained in the form of "if you don't mind, I need to,"...and I consented by my physical position and embarrassed "OK." I felt upset, vulnerable and unclear. After the first three examinations I wanted to go home, but I still consented.'

*No one prepared us for this intimate touching when we are at clinical practice. I always ask a woman if I can touch her but I never wait for her permission, for her saying: "yes, you can touch me" I just do it. (Nika)*

The frequent requirement of midwives to touch patients in intimate or sensitive areas often causes distress and embarrassment to patients. To protect patients from inhuman or

degrading treatments, the law requires that they are only carried out where medically necessary by a suitably qualified person and if possible accompanied by a chaperone to oversee the procedure [32].

In situations where the woman-midwife partnership may not be apparent within midwifery, there can be an acknowledged power imbalance present in a professional relationship that places each woman, her infant(s) and her family in a position of potential vulnerability and of potential exposure to exploitation or abuse if that trust is not respected. The trust placed in the midwife by the woman and her family is essential to enable the midwife to provide comprehensive, effective and supportive care to the woman, her infant(s) and her family. Maintaining that level of trust is the responsibility of all midwives. This means the midwife takes responsibility for, and is accountable for, maintaining professional and personal boundaries as well as assisting colleagues and the women in their care in maintaining theirs. Health care professionals need to seek permission from patients prior to touch and conclude that 'significant component of the propriety if touch is related to patient consent'. Sadly, O'Lynn and Krautscheid [33] believe that most employers don't require nurses or midwives to obtain formal consent from patients before performing any task requiring intimate touch.

For the delivery of high- quality and safe care, it is essential to use effective communication [34, 35]; unfortunately, effective communication is all too frequently personality dependent.

*I feel burdened because I know the communication and terminology is completely inappropriate: "push like you are going to poop and pee-pee, good girl)...", unpleasant (pause), inappropriate....(Dora)*

Midwifery students realize that the communication between midwives and women is often inappropriate. These so- called communication failures are, as Leonard et al. [35] pointed out, an extremely common cause of inadvertent patient harm; therefore, it is critically important that health care providers create an environment in which individuals can speak up and express concerns to alert to unsafe situations. Nonverbal communication is one aspect of communication and is defined as a variety of communicative behaviours that do not carry linguistic content [36]. It can be described as a gesture, touch, posture, facial expression, eye contact, etc. [37]. A great amount of nonverbal communication can be seen in midwifery work. It is used to express and communicate thoughts, feelings and emotions and to establish and maintain a relationship.

*Sometimes they (older mentors) simply come into the room give same instructions, (pause) "empty words and this is it. They don't even look into their eyes. (Nora)*

*Clinical mentors don't think about this (intimate touch) much. They don't respect the intimacy and privacy of a woman...and you are chough somewhere in between the mentors' demands and the women's wishes (sighs) if you want to survive you simply need to "switch" of. (Dora).*

The 'switching off' is a passive behaviour, which can lead to manipulative behaviour. Students are, because of the pressure of gathering the expectant number of procedures, pushed into the situation where they manipulate with women. If the mentors are not providing safe and supportive care, neither are the students. As Fowler [38] pointed out, midwifery mentors have various opinions of professional accountability, depending on personal experience, which

consequently influences student protégés accordingly. *I was missing a few vaginal check-ups... A midwife told me to go and get them....I said to the woman I was going to do a vaginal check-up... the woman replied that she had been checked-up downstairs (at triage) but I insisted as these check-ups are made also here despite being examined half an hour earlier (pause) honestly I didn't want to do it... I didn't want to... but I felt the pressure... that reaction of hers... I saw she was hardly waiting to pass, hardly waiting for me to finish and leave the room. (Nora)*

Students were unable to act assertive. They were not able to express themselves with confidence and without having to resort to passive, aggressive or manipulative behaviour, which is, as Bishop [39] states, assertiveness. Assertiveness can also be defined as a core interpersonal behaviour and a key to human relations [40]. It is a skill and capacity of interpersonal communication [41] that can be taught [27]. The problem occurs when a midwife, who is at the same time a clinical mentor, loses her assertiveness. An assertion cycle is a tool to guide and improve assertion in the interest of patient safety.

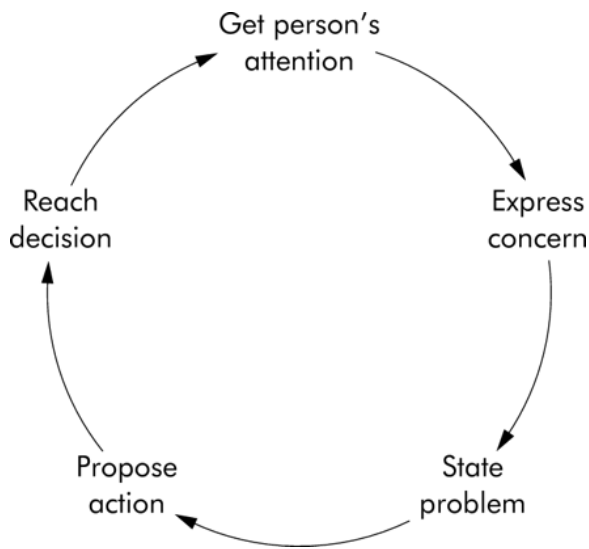


Figure 4. Assertion cycle [35]

The social influence of behaviour, which means that the behaviour of one person affects the behaviour of another person, was described by more than one participant.

*If you want to survive, you have to start acting like them (mentors) (Dora).*

The statement above is an apparent sign of apathy and fatigue, which is a reality in health care. Weinstein [42] points out that fatigue is not only mental or physical exhaustion and that the person might feel tired through physical and mental effort. It is undeniable that midwifery work is physically, but mostly mentally and emotionally, demanding.

*It is hard. The women doesn't thrust you, the mentor doesn't, thrust you, you don't thrust yourself, because you don't, ' know what you are doing.... (Lila)*

The participants themselves showed indicators of fatigue and apathy as they exhibited lack of energy and intention, poor decision- making, lack of initiative and poor communication.

*...at the beginning of a study you think all the time about how the person feels, what she is going through. Later on, you become like a robot.... (Lila)*

A responsibility of every one who works in health care is to take over the responsibility for fatigue and to find balance between personal and professional life. Students should be protected from too much stress and offered ongoing support by their clinical mentors. It is alarming that students feel fatigue and apathy.

#### 4.2. Boundaries being crossed

The category **Boundaries being crossed** considers the students' experiences of negative emotions and their ambivalent attitudes towards intimacy and a naked body and the vulnerability of all involved.

Boundaries bring order to humans' lives; they empower and protect an individual from the ignorance, meanness and thoughtlessness of others. There are several types of boundary violations:

- The intrusion violation
- The distance violation
- Physical boundaries
- Emotional boundaries
- Ethical boundaries
- Professional boundaries

A midwife, who is at the same time clinical mentor to midwifery students, may, among other things, violate a boundary in terms of physical contact, intimacy, disclosure, etc. Even though some boundaries are clear cut, all boundary violations are extremely complex. There are two types of professional boundary matters: boundary crossings and boundary violations. Boundary crossings are described as brief excursions across professional boundaries that may be inadvertent, thoughtless or even purposeful. Boundary violations refer to the misuse of power or the betrayal of trust, respect or intimacy between a midwife and a woman [43]. Morrall [44] points out that students are thought of as 'the bottom of the pile' and, because of their desire to become part of the team and to become accepted, can overtake their learning experience. It is a fact that within clinical environments, there is a hierarchy in the workplace, which can create an inferiority complex and fuel the adoption of bad behaviour.

Within the midwife/clinical mentor – woman – student relationship, the woman and the student are often vulnerable, because the midwife is in the position of power. When a student is observing the boundary crossing and boundary violations or he himself is being exposed to it, he is in jeopardy of developing negative emotions such as fear, guilt, shame, anger, anxiety, disgust sadness, doubt, etc.

*At that point I felt like we didn't do all we were supposed to do, to protect the woman's intimacy...there is this feeling of responsibility, guilt. (Nika)*

Childbirth itself is an emotional event for all involved: the woman, her partner, the midwife and, if present, the midwifery student. The emotions can be both profoundly positive and, unfortunately, also deeply traumatic.

*...I told her (woman) that we are going to do vaginal examination every hour. Instantly I noted that something isn't ok....she told me that she was raped as a child by her father...I ensured her that we will do everything to protect her, that we will minimize the number of exams. I told the mentor about it....the mentor didn't give much attention to it and just continue with the routine procedures. After her doing the vaginal examination the woman didn't want the doctor to do another vaginal examination.... the doctor ignored her request and literally pushed her fingers inside her....at that point I left the room, I couldn't be there anymore, I am still having bad dreams. I heard the woman screaming: Leave me alone, I don't want this, you are hurting me and the doctor: "relax we are just trying to help you". Horrible...horrible (pause) I stood there feeling terrible wishing to disappear... (Lila).*

This deeply traumatic experience of one of the participants shows the intricacy of contact while accomplishing routine clinical tasks. Midwives most often 'get through the work' by focusing on task-oriented aspects of care, and much of the learning of midwifery students still takes place 'on the job', whereby students learn to manage emotion by adopting a task-oriented approach to care [45]. Students often feel challenged and intimidated to provide intimate care in the health care setting, as they are faced with social, professional, academic and peer expectations and experience high levels of stress when providing intimate care [30]. *Vaginal examination was one of the worst things for me. You are reaching so deeply in to the intimacy of a woman. I am always wondering how the husband deals with this, because I am feeling extremely unpleasant invading the privacy of his wife's vagina. (Nora)*

Senior midwives seem to retain their dominant position by means of unwritten rules, which are often idiosyncratic and most common in the accounts of student midwives, who are making the transition from being 'outsiders' in midwifery to 'insiders' and are keenly aware that senior midwives are the gatekeepers to this passage. Furthermore, students are especially vulnerable in this respect, as it is the senior midwives who assess their clinical ability [46]. *Every time I feel so scared and nervous. I am hoping that everything goes well and that the woman won't comment on me and my work in front of my mentor. (Jona)*

According to Crossan and Mathew [30], students aim to achieve a balance between their own comfort and discomfort levels versus the woman's level of comfort and discomfort when providing intimate care. In the model of intimate care situations affecting comfort and discomfort in women and the care provider, both the student and the patient are likely to move in and out of their comfort and discomfort zones. *For several times I have asked myself how do they feel about me being present at this intimate event (birth)? Do they like me or do they have a bad feeling when I'm looking and touching their vaginas, breasts, perineum.... (Nika)*

The participants perceive the intimate touch as a stressful event for them and for women. They are aware of the vulnerability of all involved.

*For me, the first vaginal examination was very stressful, as it was very painful for the woman. I felt as I did something bad to her. Afterwards I had to sit and drink a glass of water. (Ina)*



All involved in midwifery education need to know how to manage student stress effectively. As pointed out by Prymachuk and Richards [47], this can be achieved by ensuring that personal teachers play a key role in supporting students, especially when students self-report high levels of stress.

### 4.3. Broken dignity

**Broken dignity** is the category that highlights the importance of understanding how invading someone's intimacy can be a human rights violation and, therefore, an exploitation or an abuse.

Dignity is a global concern in health care and fundamental for every patient. To lose dignity means that a person has been exposed in ways that affected his worth [48]. There has been a growing interest in, and concern about, dignity, or, rather, the lack of it, in care services [49]. Quality of care includes quality of caring, and this means how personal care is the compassion, dignity and respect with which patients are treated. *Today there was a woman giving birth and the door was open. Me and my colleague were passing by... they simply don't close the door and they don't respect the intimacy. And those terrible hospital attendants... in and out of the room. (INA)*

Midwives, whose roles bring them into intimate contact with others, can easily undermine women's self-worth, usually through sheer thoughtlessness such as neglecting to close the door [48].

Mentors should be role models for their students [50] and should never put the students in the position where they are forced to invade another person's intimacy.

*It depends on the department... and experience of the supervisor... the longer her career lasts, the less sensitive she becomes for woman's dignity and her intimacy. (LILA)*

Invading intimacy is also an area of concern for midwifery students. They understand that, for many women, vaginal examinations bring up issues of sexual intimacy, invasion of privacy and vulnerability [51]. *I don't want to do serial vaginal examinations as well... I feel how vulnerable are women at that point. (Petja)*

There is also a concern of violation of human rights when invading into another person's intimacy, as human rights and human dignity are intimately linked [52]. As Sulmasy [52] points out, all human rights depend upon the concept of human dignity. The right not to be experimented upon without consent is an absolute human right in health care.

*The most terrible for me is giving enema or doing vaginal check-up, shavings... as I know they feel terribly as they are already explaining in advance »I am shaved« or »I'm not shaved«... (SARA)*

It is the responsibility of a clinical mentor to protect the dignity of a woman and of a student. All midwives should act upon a code of ethics. The Slovenian Midwifery Code of Ethics (Kodeks etike za babice) [53] acknowledges women as persons with human rights, seeks justice for all people and equity in access to health care, and is based on mutual relationships of respect and trust and the dignity of all members of society.



## 5. Conclusion and recommendations

The findings of this study are somewhat disturbing, because it is quite clear that midwifery students are not appropriately prepared for the intensity of intimacy and emotions related to their work at clinical practice. The students are classified as young adults, but they might still be in a process of looking for their identity and, consequently, still building their personality. It is well known that young persons' sexuality is about growing awareness, experience and expression of eroticism, sexual pleasure, intimacy, sexual orientation and gender identity. It is less known that it is also about the social rules, economic structures, political battles and religious ideologies that surround physical expressions of intimacy and the relationships within which such intimacy takes place [54].

In a way, this study opened Pandora's box. But, even though, by definition, this means to get into a situation over which one has very little control or to create an uncontrollable situation that will cause great grief, the researchers believe it was a box that needed and was meant to be opened. The midwifery students in clinical settings and the women who are seeking help, advice or care from health care professionals need to be protected from abuse of all kinds.

All students, while on practice placements, should be supported and assessed by a registered practitioner, who has undertaken an approved mentor preparation programme, with mentors expected to support, facilitate learning and assess the clinical competence of pre-registration students within the practice setting [55].

It is apparent that very few midwifery textbooks cover the topic of intimate touch and very few midwifery curricula focus on the complexity of intimate touch; therefore, midwifery students gain their skills by trial and error in clinical practice, which is far from appropriate. The researchers noted that students give great thought to intimacy issues while on their clinical practice and that they fear that their touch will be misinterpreted, and from the literature review, it is clear that many women have mixed feelings about intimate touch provided by students. Therefore, midwifery students should have the possibility to reflect on how they understand, perceive and approach intimate touch. Midwifery education should be based on the development of evidence-based strategies for intimate touch, and midwifery educators should consider discussing with students the anxiety and uncertainty that they feel when providing intimate touch.

The researchers believe that, regarding this study, it is not enough to write only a conclusion and recommendations, but it is necessary to act proactive. Therefore, one of the researchers, who also has a degree in marriage and family therapy, will use her knowledge of counselling and start an assertiveness training programme, which focuses on how to react to difficult interactions in daily life for midwifery students in order to help the individual change how they view themselves, improve their assertiveness, properly express their individual moods and thoughts and further establish self-confidence. Lin et al. [56] found out that the assertiveness training programme significantly increased the assertiveness and self-esteem of students, especially among individuals with low assertiveness and self-esteem.

The development of a theoretical framework and evidence - based strategies regarding intimate examination would be of benefit to the clinical practice, supervision and education of midwifery students. It would provide students with the best possible educational experience and an optimal midwifery care to women. The conflict between educational needs and ethical requirements is especially acute in the teaching of intimate examinations. The teaching of intimate examinations poses ethical problems, not only for the student but also for educators, because students must learn, but patients must be protected [57].

The methodology used in this study provided a unique insight into the perception of Slovenian midwifery students on intimate touch in clinical practice. The findings of our study cannot be generalized but can help in building up the awareness of the importance of the issues of sexuality and intimacy in midwifery. Clearly, there are implications for further research on the topic of intimate touch, which should include women's perspective as well as the perspectives of mentors and faculty educators.

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