INTRODUCTION

Touch is arguably one of the most important of the five senses classified by Aristotle. The role of touch is firmly anchored in Biblical scriptures where it served as a vehicle for blessing and healing; for example, Isaac blessed his son Jacob by laying hands, and Jesus cured countless sick people of their ailments through touch.

The amygdala is associated with emotional reactions linked to human proximity, but touch cannot be understood purely in terms of proprioceptors, dorsal root ganglia, and the like. Modern medicine needs not deviate from more traditional frameworks in which touch is understood humanistically and interpersonally, involving the expression of empathy and solidarity. Touch has the potential to communicate, soothe, and heal, and medicine is diminished if it avoids the exploration and utilisation of the power of touch.

Many of the commonly used consultation models in general practice employ the traditional framework of history, examination, diagnosis, and the formulation and negotiation of a treatment plan. In the clinical examination touch is re-framed as ‘palpation’ probing for abnormalities or percussing a chest. Touch is then used to explore the body-object. While this is an important diagnostic modality, it also can leave the patient feeling neglected or objectified. The patient’s disease process can itself foster feelings of confusion, powerlessness, and isolation which may be exacerbated when he or she is examined by a physician or admitted to a hospital, identity-banded, disrobed, then poked and probed in a way that may prove de-humanising.

Along with this ‘objectifying touch’ much of medicine is characterised by an ‘absent touch’. That is, direct doctor-patient contact often gives way to a reliance on technological devices that help diagnose, and later treat, the patient. It is not unusual for a doctor to stride into a hospital room and, rather than reach for the patient, reach instead for the chart with the latest lab results.

There are many reasons why GPs might avoid the use of more personalised touch. The litigious climate in which we work may have made them averse to violating patients’ boundaries, damaging both clinical judgement and patient trust. The media and the medical defence organisations’ reports are littered with examples of healthcare professionals abusing their trusted status and committing acts of sexual indiscretion through the use of inappropriate touch. Do GPs believe that effective health care can best be delivered by using ‘objective’ examination and intervention, technology, and verbal skills alone?

Yet, therapeutic touch is pivotal in certain areas of modern and traditional medicine, including physiotherapy, osteopathy, chiropractice, and acupressure. Can verbal skills replace the expert hands of a physiotherapist in relaxing tight muscles, or those of a chiropractor realigning a contorted spine? Can words alone replace the touch of a GP who reaches out to a distraught patient to demonstrate empathy and to recognise suffering? Touch can be used to bridge the emotional and physical gap between a physician and patient. It can directly express care, compassion, and comfort. It has the potential to play an important part in the healing process, reinforcing patient trust and concordance, along, perhaps, with the ‘placebo effect’, triggering the body’s own capacity for self-healing. This requires a cooperative relationship in which touch is offered skillfully by the physician, and welcomed by the patient, who is a full partner in the communication. However, the use of touch can elicit misunderstanding or have a negative impact if perceived by the patient as invasive or inappropriate.

PATIENTS’ VIEWS ON TOUCH

I wanted to begin to explore patient’s thoughts, ideas, and possible concerns about the use of touch in the general practice consultation. The principal areas of interest were the role of the sex of the patients and GPs in the use of touch; specific reasons why patients were not comfortable being touched by their GP; the position on the arm or hand where patients felt that touch was no patient-identifying information on the questionnaire, and slightly more patients finding being touched by a female doctor more acceptable.

The two most common reasons for patients not feeling comfortable with the use of touch for reassurance were the invasion of personal space and feelings of unease regarding the sex of the GP. No one cited religious, cultural, or familial beliefs discouraging the use of touch in the context of reassurance, although there was relatively little socioeconomic or ethnocultural diversity in this patient sample. The sex of patients made little difference to the reasons they cited for not feeling comfortable with the use of touch for reassurance, although a greater proportion of males felt that touch invaded their personal space. In relation to the position where patients felt most comfortable being touched by their GP, a more proximal position on the arm was favoured. The back was the most popular alternative location where patients felt it

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Table 1. Main findings

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<tr>
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<th>Touch by male GP, % (n/N)</th>
<th>Touch by female GP, % (n/N)</th>
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<tbody>
<tr>
<td>Male patients that felt comforted</td>
<td>75 (154/205)</td>
<td>77 (158/205)</td>
</tr>
<tr>
<td>Female patients that felt comforted</td>
<td>83 (119/140)</td>
<td>92 (110/120)</td>
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<tr>
<td>Overall</td>
<td>80 (373/475)</td>
<td>84 (368/435)</td>
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appropriate to be touched for reassurance. A greater proportion of females than males thought the back was an appropriate place to be touched. The remaining patients did not feel it was appropriate to be touched anywhere other than the arm or hand by the GP for reassurance, again proportionately more females than males.

WHAT DOES THIS MEAN?
It seems that a large majority of our patients would be comforted by the use of touch by their GP. The demographics of the population recruited are those of a relatively socioeconomically deprived and ageing population, with relatively little ethnic diversity. If this study were to be repeated elsewhere, the results might well be different. The study may also have some element of selection bias which results from the distribution technique of the questionnaires. There is no in-depth statistical analysis of the results but nonetheless they have interest and meaning, socioeconomically deprived and ageing doctor–patient relationships. They contribute to the strengthening of the modality that patients feel can be an integral part of the consultation. Information of this kind may help GPs to recognise the potential value of using touch in the consultation, to remove taboos around the subject, and to value of using touch in the consultation, to contribute to the strengthening of doctor–patient relationships.