The pandemic, not yet over, has already significantly changed how primary care functions. GPs, typically innovative and adaptable, swiftly switched to ‘remote’ consulting in March, with telephone and video consultations the norm and face-to-face the exception, albeit still available. GPs express concerns that the ‘flight to the virtual’ may lead to losses, including the sapping of energy and joy and an increase in health inequalities. But there is another deeper issue at stake. The loss of touch in our personal encounters threatens the wellbeing of all of us and, in particular, for those who are vulnerable and living alone. In the context of our professional encounters, the physical examination, aside from its diagnostic value, is an important mode of communication and a skill that requires embodied learning and practice — ‘body pedagogics’. We should be wary of discounting its value.

HUMAN SKIN AND THE ‘MAGIC’ OF TOUCH

Giles Dawnay in the BJGP posed the question: ‘Could our skin be far more than just a barrier to the elements?’ My answer in health inequalities. But there is another sapping of energy and joy and an increase in health inequalities. But there is another deeper issue at stake. The loss of touch in our personal encounters threatens the wellbeing of all of us and, in particular, for those who are vulnerable and living alone. In the context of our professional encounters, the physical examination, aside from its diagnostic value, is an important mode of communication and a skill that requires embodied learning and practice — ‘body pedagogics’.

We have all read or heard the harrowing stories from caregivers and from those who have lost their loved ones in COVID-19 who fear to touch their partners, to their loved ones, and for healthcare professionals looking after patients with COVID-19 who fear to touch their partners and children when they go home.

We have all read or heard the harrowing stories from caregivers and from those who have lost their loved ones in COVID-19 times.

THE PHYSICAL EXAMINATION

Abraham Verghese and Ralph L Horwitz have made a passionate call for the reinstatement of the physical examination, arguing that it not only avoids unnecessary tests but also helps to develop trust, empathy, and relationship building.

In my 35 years as a GP I have been surprised by the revelations that have flowed from the many physical examinations. This practice has often felt as an almost sacred ritual eliciting trust and information that bypasses the verbal and visual. Yes, there were the diagnostic surprises — the unexpected lump, the hidden bruises or scars, the unsuspected breech, or perhaps a ‘secret’ tattoo or body-piercing. But often the revelations were stories of pain and suffering — sexual assault in childhood, torture in another country, a coercive or illicit relationship, an unmourned bereavement, hidden fears. And as I percussed the chest, or palpated the abdomen, or even undertook an intimate examination, I would hear ‘I have never told anyone about this, doctor.’ Touch became a door to a hereto undisclosed inner world.

I use the examination to further the dialogue, to hear more about people’s lives, who they are, what they do, their family, their hobbies. And this dialogue is conducted at two complementary levels — with our speech and our bodies. The intimacy of contact encourages a more humane and authentic conversation than peering at a blood test or X-ray results on a computer screen. This is not to disparage the usefulness of test results or the telephone

“... touch is more powerful than language and central to human life ... In my 35 years as a GP I have been surprised by the revelations that have flowed from the many physical examinations ...”

Paquita de Zulueta
consultation and telemedicine. They may well be lifesaving in some circumstances and do offer convenience, although not necessarily speed.

Visiting the frail elderly when working for the emergency service, I was struck by their anguished loneliness. Yes, the carer had filled the dosset box, and checked that they had ‘taken their meds’ and had eaten [maybel], but what seemed to give them solace, to elicit a tentative smile or even tears of relief, was when I held their hands, gazed and trembling, in a firm, warm clasp. They longed to have a chat, to reminisce, to share a cup of tea. I would try to bring some humanity to the encounter, but time pressures limited the scope for this.

Phenomenology — a philosophy of embodiment in which mind and body are inseparable — offers us rich insights into touch. Maurice Merleau-Ponty reminds us that the lived body is reversible or ‘double-sided’ in that it is both an experiencing subject and a material object in the world.10 This ‘dual existence’ as both consciousness and physical matter is probably unique to humans. Touch brings us in contact with others, but also with our own embodiment. When carrying out a physical examination we are observers and examiners, but also subjects who are responding to our patients’ responses and perceptions of us. It is a form of dynamic dialogue and we oscillate between our subjectivity and objectivity.11

In the intimacy of the physical examination we, as both patients and clinicians, render ourselves more open, more vulnerable. The etymology of the word is relevant: the Latin intimus signifying ‘innermost’, and intimare ‘to impress’, or ‘make familiar’.

The avoidance of touch may be linked to the understandable fear of being seen as invasive, of transgressing boundaries, or even being accused of sexual molestation — but is there also an unspoken fear of engagement, of getting ‘too close’ to our patients, of being ‘touched’ by their suffering?

A TYPOLOGY OF TOUCH

Touch can help us as clinicians to discern, detect, and diagnose, but can also allow us to express empathy, reassurance, comfort, and presence. A study of GP’s and patients’ perceptions regarding touch revealed that all patients and most doctors believed that ‘expressive touch’ improved communication.12

‘Healing touch’ has a long history dating from classical times with the myth of Asclepius, the Greek god of medicine. Drew Leder describes the impersonal ‘objectifying touch’, and the ‘absent touch’ when technology displaces human-to-human interaction. Objectifying touch — also described as ‘procedural’ or ‘instrumental’ — is necessary, but if unaccompanied by any form of empathy or reciprocation can leave patients feeling bereft and alienated from their own bodies. Leder describes how those in the ‘kingdom of the sick’ yearn for the caring touch: ‘Ultimately, healing touch is not something the clinician does or the patient. Touch unfolds in the reciprocal space between the I-Thou relationship.’ 13 This reciprocal touch is described in the literature as ‘relational’, ‘empathic’, ‘compassionate’, or ‘caring’.

From my lived experience as both patient and doctor, I believe it is possible to use both kinds of touch concurrently — a ‘compassionate objectivity’. A study with Canadian family doctors appears to confirm this: the GP’s viewed the physical examination as practising good medicine and that the ‘gnostic’ (intellectual, objective) elements were inextricably linked to the ‘pathic’.14

CONCLUSION

We are embodied social beings. We thrive on nurturing relationships. Touch forms a key part of those relationships in everyday life but is also a powerful form of communication for clinicians, allowing for wordless dialogue, presence, and embodied empathy. Touch hunger’, a term coined by Tiffany Field, threatens our sense of being-human, and our ability to ‘impress’, or ‘make familiar’.

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