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A Matter of touch
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Take a seat: when touch is more than just a touch

There is an ancient practice in medicine, already used by Hippocrates and Galen, that sees its scientific description only in the 18th century thanks to Leopold Auenbrugger¹. When he became a doctor, he did nothing more than repeat what his father, an innkeeper, did; when he had to figure out which barrels were full, half-full or empty, all he did was tap them. The young doctor would learn to perceive even the most subtle differences in the tones produced. “The chest of a healthy person, when struck, emits a sound,” like barrels! In a book that ended up in oblivion, Auenbrugger first scientifically expounded percussion, a cornerstone of anatomically based diagnostics, and used in the clinical medicine to demarcate the cardiac and abdominal areas: percussion of the chest recognizes possible alterations in the organs contained below, such as pleural effusions and pulmonary thickening; and in the abdomen, by the different quality of sound it takes on depending on whether air is present or not.

Percussion, along with palpation and auscultation, marked a passing moment when physicians began to investigate, to touch the body scientifically, snatching the job from the surgeons.

Touch during medical procedures can be soothing or traumatizing. It can be administered gently and compassionately; alternatively, it can be handled sloppily, negligently or even, at worst, incompetently. Historian Paul Stepansky has written a book about this, *In the Hands of Physicians. Touch and Trust in Medical Care*,² focusing on the importance of human compassion (nothing religious here) in the medical and nursing profession.

“Many patients feel that being touched is important for getting better,” he comments. His father was a general practitioner in a small Pennsylvania town, and Stepansky saw firsthand the effect of those personal relationships. “Medicine then was all about touch, and patients welcomed the clinical-diagnostic touch, which was an integral part of the medical profession and, in

part, because physicians were part of the community, medicine was about the laying on of hands.”

Now, in the age of digital medical records, where physicians may spend much of the visit staring at a computer screen, the physical connection between doctor and patient may prove even more important. “Touch promotes trust,” Stepansky says, “not just talking or ordering additional clinical tests” that are due and necessary, of course.

By the way, the already mentioned phenomenologist Merleau-Ponty, in his writings introduces a passage in the application of the phenomenology of touch to the question of healing. He cites the example of a psychiatrist healing a severely disturbed patient by touching his throat with his hand. “In curing (certain illness) psychological medicine does not act on the patient by making him know the origin of his illness: sometimes a touch of the hand puts an end to the spasms and gives the patient back his speech. The patient would not want to accept the meaning of his ailments as revealed to him without the personal relationship formed with the doctor, or without the trust and friendship felt toward him. Ultimate healing involves an existential conversion of one bodily subject into full tactile communion with another.³”

In contemporary health care, touch – the contact between the doctor’s hand and the patient’s body – appears to be dying out. The growing role of imaging, CT scans, MRIs, and ultrasounds, is diminishing the reliance on touch as a method of making diagnoses. The increasing pressure to move patients more quickly through an increasingly hobbled health care system leaves health care providers with less time, less opportunity to make contact. When the minutes physicians spend with patients are cut, that stumped time is usually the time available for human touch and contact.

Yet, despite the advent of scanners, robots, and artificial intelligence, the physician’s hand remains one of the most valuable diagnostic tools in medicine, as many doctors firmly believe. Touch creates a human connection that is especially necessary in this increasingly detached and impersonal age. Medical practice is replete with situations in which touch does more to comfort and reassure than any words. Doctors use touch as a way to comfort a patient, as well as to detect clues about possible abnormalities: a painful upper right abdomen where it points to a gallstone or a lump that might signal

a tumor. As they listen to your heart, they might place a hand on your back to listen for breaths. Tap your knee to assess the nerve reflex. In many cases, without a physical diagnostic exam, clues to the underlying health problem could easily slip through the cracks.

What can a physician learn by touching a patient that can be acquired in some other way, such as through chart review, screen or eye glance, stethoscope or digital imaging, or through any of the myriad of laboratory results available?

Puzzling is the anecdote recounted by Stanford University physician Abraham Verghese⁴ in his now iconic TED Talk, in which a woman, after two years of bouncing from doctor to doctor, arrives in desperate condition at the emergency room in the city where Verghese lives. Doctors think it's a pulmonary embolism, but an MRI eviscerates images of a palpable tumor in her breast, and metastases spread everywhere to the rest of her organs.

"No doctor in two years has performed palpation on my breasts; no one has given me a complete physical examination until now," the woman would later recount. Physical, tactile attention would have been life-saving for her. Based on where doctors spend most of their time, an anthropologist walking through our hospitals could easily conclude that the patient is in the computer while the individual in the bed is a mere placeholder. Because MRIs, angiograms and PET scans provide us with incredible images of the bowels of the body, and have created the illusion that there is no other way to *see* the body. For this reason, when a medical expert shows a series of findings about a body and then makes inferences that connect the findings into a convincing story, it always seems to amaze students.

"I want to talk to you about one of the biggest innovations in medicine in the next ten years: touch, the power of the hands," is the opening line of Abraham Verghese's TED. Without of course denigrate the technological advances that permeate medical practice, Verghese has long been a leading proponent of human touch in medicine. He provocatively calls for the return of the traditional individual physical examination, which, along with listening to the patient's history, is at the heart of the doctor-patient relationship. He likes to remind students that when they shorten the physical examination, they

shorten the nature of that relationship. He is an advocate of the sacredness of the doctor-patient relationship: he believes that the doctor's touch makes a difference to patients because it conveys the physician's undivided attention.

In one of his writings⁵, Verghese asks what could be the ultimate meaning of the sense of touch, which allows for so many interpretations.

It is a question that occupied, among others, Charles Darwin. Clearly, at one level, touch is simply protective: it warns us of contact. Think of tickling: if the contact is with ourselves, we are not ticklish; if the contact is from a person, it can cause tickling. Freud pointed out that the person who tickles another has a kind of reward from his role: tickling combines aggression and closeness, while the tickled person gives up some dominance over his own body. Laughter suggests consent, but this is belied by the writhing and wiggling movements in an attempt to escape the tickle. Looking up the word *touch* in the dictionary, Verghese is fascinated by the complexity of the sense of touch, and touching. Many uses of the word touch have to do with control: "losing touch," "be in touch with oneself," "easy touch," "touch a nerve," to name a few. After spending an evening tickling and being tickled with his son, Verghese recounts that going to bed, he felt overwhelmed to have come to a simple, yet profound, insight: touch is more than just touch.

In most of our lives we as human beings use touch only at times and in certain situations, and one of them is in the medical field, and it is sadly fading away: the physician has the privilege of examining the body of another human being and reading it, interpreting it. "I have become more and more aware that examining patients is pretty much the only way doctors come into contact with patients. If we consider medicine primarily as a cognitive exercise aimed at getting certain numbers, algorithmic figures, none of that matters. But, if we still consider medicine as *ars scientifica*, much of the art is in listening, finding the nuances of the story and deciding what they mean. The patient visit represents an important moment, where something happens between patient and doctor. I hear from many anecdotes that patients find it very valuable even though we think they don't," he tells me during an interview⁶.

One misses a transcendental rite, a primitive rite. Because for Verghese, it is a rite; a stranger enters the doctor's office and begins to tell extremely

intimate things, which he would not tell even to an intimate friend, undresses and lets his body be examined in such a way that under any other circumstances it could be considered an assault. In this ritual, the obligation is to perform an examination with competent hands, where medical examination has a therapeutic effect. But mind you, Verghese is not referring to so-called therapeutic touch, which we will discuss later, because in this context he wants to refer to a ritual that does not resemble any other kind of social interaction.

All rituals have to do with a transformation, think of a baptism, a wedding, a funeral. Physical examination also has parallels with rituals in certain trades that are passed down from generation to generation. Generally, if these trades are not valued, they will die out. And Verghese, who is also a creative writer, says, “If you look at a ritual like, for example, Indonesian sword making, you could see that there are very elaborate ceremonial swords. You need a relationship with a master craftsman. You need a long apprenticeship. There is specialized terminology. There is a specialized work space. There is specialized clothing. Every aspect of physical examination can be compared to these trades. One of the obvious truths about these trades is that if they are not taught or valued, they will in fact die out.”⁷

In the case of the ritual of hands examining a patient, the physical examination marks the transformation of the relationship between doctor and patient: a situation of intimacy is created that paves the way for the doctor to communicate information and recommendations that are received by the patient in a different way, the moment trust is established. “When this examination is done something important happens. Whether it is the visit with a difficult or grieving patient, or with a loquacious, hypochondriac patient, the moment I perform my tactile examination, I often have the feeling that the examination becomes fluid, a kind of dance, one in which the patient is an active participant, calming and reassuring, because the examination itself had brought about this change. I always tell my students, who probably don’t know how to fix a car or get a haircut, that nevertheless we can judge the good quality of our mechanic and hairdresser by how well they know how to touch cars and hair. Patients make the same judgment about us,” Verghese tells me. “Physical examination is about an individual granting permission to another

individual to touch his or her body, semi-clothed and sometimes naked, to probe the most delicate and private places. Physical, tactile examination, therefore, is about trust, it is about a sacred privilege. We have an organism in front of us, the biology of this organism is sick, angry, and we have to understand how and why. But there is more than just that, there is a subtext in human beings, especially in the most serious illnesses, a motion of infantilization whereby the subtext asks, ‘Mommy and Daddy tell me it’s going to be okay.’ Perhaps it sounds patronizing, but physicians have an obligation to convey not necessarily in words the message of ‘I’m taking care of you, we’re going to do this together, not necessarily succeeding in curing you but being by your side throughout the treatment.’ When I talk about the power of the hands, that’s what I’m referring to.”

Nothing is more accurate than a CT scan or an MRI, of course – if the doctor on duty competently interprets the results. But the touch, the physician’s physical examination, has an inherent characteristic of intimacy, a manifestation of caring. Verghese likes to quote Francis Weld Peabody⁸ when he wrote that “one of the essential qualities of the physician is an interest in the human being, for the secret of caring for the patient is to care for him”: of lapidary simplicity, yet. “We have created a work situation where there is no longer merit in doing a good physical examination,” Verghese points out. Students are still taught clinical examination skills, even though pressures to reduce hospital stays mean fewer opportunities to spend time examining patients. It is the image that makes the biggest difference. Digital technology provides much more accurate information than physical examination, and there is a sense that students no longer have to trust their hands to see or that touching is a waste of time. Perhaps that is not the point, because there is more to touch than just acquiring information.

Verghese recalls several moments in his career when the medical physical examination became a powerful dimension. Indelible scenes for which it took years to find peace. Such as when he regularly visited the beds of dying AIDS patients before a treatment came along. He remembers the reluctance, the sense of failure he felt during the home visits. He didn’t know what to do, what to say. He would overcome the discomfort, the embarrassment by taking

refuge in the only role he knew how to play at the bedside, the physical examination. Then he would feel the pulse, gently lower the patient's eyelid to see the color of the mucous membrane, then examine the tongue, probe the hollow chest with the ancient technique of percussion, listen to the lungs, then palpate the abdomen: his ritual. He remembers countless pairs of eyes of so many people, all long dead now, but their names are still vivid in his head: huge, tortured eyes in hollowed-out eye sockets, staring up at the doctor as he performed the examination.

"I will always remember an HIV patient. I went, as usual, to visit him at home, where his mother told me he had not responded to any stimulus for a whole day. As I always did, almost instinctively, I began the visit by grabbing his wrist to feel his pulse. And immediately I noticed that with his free hand the man began to unbutton his pajamas and made a faint gesture to invite me to examine his chest. This moved me deeply. My touch had not only value for me, but also for him," he tells me during the interview, and goes on to telling me another anecdote, from when he was teaching young doctors at a VA hospital in the 1980s, demonstrating a physical examination on an old veteran. He had a pleural effusion. During the examination, the man stayed silent but suddenly he cut in, exclaiming, "My doctor used to do that when I was a kid. He was a good doctor." In his mind he had equated the touch with the care. The doctor-patient contact had been triggered.

There are those in medicine who think that touch can sometimes act as the first placebo effect, a portentous body-mind axis. One thinks of the beautiful experiments done by Alia Crum, who somehow has measured just that. Crum heads the Mind & Body laboratory at Stanford University, and as an undergraduate she was impressed by the work of Fabrizio Benedetti⁹ on the neurobiological effects of placebo.

The Crum lab has begun to investigate where the placebo effect occurs, this time also considering the aspect of the physician's examination at the patient's bedside. The study involved giving test participants a shot of histamine, an allergen, which produces itchy red pimples. They were then given a cream – unknown to them, a fragrance-free hand lotion – and told that

it would have relieved the irritation. During the experiment, the cream was never changed, but the behavior of the health worker spreading it was. In some cases, the health worker was friendly and knowledgeable, spreading the cream circumspectly, like a caress; in others, the health worker was disengaged and distant. In the first group, participants saw a decrease in their rashes. The placebo treatment had been constant, but the placebo effect had not, and the participants' minds, shaped by the operator's performance, had made a difference, Crum measured¹⁰.

The placebo effect is an important component in all treatments. We can increase its influence through simple things like attention, presentation and expertise, the sense of touch, in this case. Throughout the Western world, especially for diseases with chronic pain, alternative medicine such as acupuncture and reiki are increasing exponentially. There is not even half a scientific evidence that these practices benefit, but many people, even those who believe in science, are using them. There must be a reason for this. The common denominator shared by these practices is touch, presence and caring. "Touch is more than just touch, I cannot think of anything else. Could it be that touch acts, precisely, as a placebo effect?" Verghese wonders.

Roger Kneebone, a combat medic in South Africa before becoming a general practitioner upon returning to England, recalls that when he was a medical student. He spent hours with patients, examining them on the ward, drawing blood and assisting in operations. Initially, I felt awkward, inept and embarrassed at the prospect of physical contact, because touch carries with it social conventions and taboos that are difficult to overcome. But gradually, through practice, I gained more confidence. Examining people, touching them, stopped seeming strange. Apparently, the purpose of these examinations was to gather diagnostic information and transfer data to medical experts. Kneebone had to describe the characteristics of a lump, for example, or find out if there was abnormal texture under the skin. "What I didn't realize was that I was also learning a tactile language, a form of communication that worked both ways. By examining one patient after another, I was building a lexicon of touch that went far beyond distinguishing

a lipoma from a cyst. When I became a general practitioner, touching my patients was so second nature that I was almost unaware of it. It happened automatically,¹¹” he recounts.

The discussion of the power of the hands in the medical field brings us back to phenomenology. Max van Manen¹² distinguishes between *gnostic* and *pathic* touch.

Gnostic touch collects clinical data in a unidirectional process. Pathic touch, in contrast, is a two-way communication that conveys care, concern, trust, and reassurance, or their opposites if carried out inappropriately. This is the wordless language of affection and feeling, a physical communication that is both condensed and economical. The medical consultation is a privileged space where normal conventions are suspended. Where else would someone trust a complete stranger to touch any part of his body? In fact, most of us as patients would like our doctors to be light in their pathic touch, and we can recognize immediately if they are.

Yet, there are many challenges in teaching and learning this language. At the gnostic level, how do we make sense of anatomical landscapes that we can feel but not see? Rectal and vaginal examination are essential skills in many areas of medicine, for example, but it is almost impossible to tell if a student is touching what he or she thinks they are touching. At the pathic level, broadening one’s attentional focus to include a patient’s responses when performing an examination done with the hands takes a lot of practice. Social and cultural expectations vary widely, and touch can be a minefield. Embarrassment and uncertainty can be as much a part of the student’s experience as the patient’s.

According to Richard Horton, editor-in-chief of the medical journal *The Lancet*, avoiding touch is bad medical practice, although he is fascinated by new medical technologies, appreciating and promoting in the pages of his journal the discovery of new drugs and treatments to manage previously incurable conditions, admiring the ever-advancing technologies. Touch indicates the human nature of the difficult situation that the patient and doctor face together. “Touch humanizes this situation, communicates concern and comfort, conveys the idea of survival.” The depersonalization of the clinical

encounter is a serious setback for medicine. “It is time to bring touch back to medicine,¹³” writes Horton.

Debate exists among clinicians about maintaining or recovering fluency in this bidirectional language of touch in an attempt to recover a more human dimension. Neuroscience is showing that commonly accepted notion of touch, mediated through a sparse number of receptor types – that “recognize” light touch, pressure, vibration, temperature – is a gross oversimplification. Touch is a much more complex dimension than we think, as is the case with vision, where imperfect signals are processed into a rich and complex sensory experience. It is no accident that doctors talk about teaching one’s fingers to *see*. Touch is often ignored, but making sense of its complexities and assessing progress in its mastery are challenges to be embraced. Although the role of touch in diagnosis may be changing, its role in treatment is more important than ever.

In physical examination, data are acquired, but the main purpose is to establish trust, the trust that is unfortunately faltering everywhere. Doctors reassure patients, showing them concern and care, that they are doing everything possible to treat their medical conditions effectively. At the very least, patients do not feel alone in their fear. Although the process takes longer, and there is very little of it in hospital wards, many professionals would like to restore that minimal human part to put the patient back at the center. So, in our increasingly technology-driven future, doctors predict that nothing – not bureaucratic demands, not virtual doctor visits, not robots controlled by artificial intelligence – will replace the essential human-to-human connection that hands provide. And it seems that together they read the pages of Margaret Atwood, who in *The Blind Assassin*, wrote, “Touch comes before sight, before speech. It is the first language and the last, and it always tells the truth.”¹⁴