

The loss of the ‘human touch’ in contemporary medicine

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In October 2019, Richard Horton, editor of *The Lancet*, lamented:

Why don't doctors touch patients anymore? Having had the privilege of attending clinics in the UK's National Health Service almost every week since March this year, I can honestly say that at no stage has any physician, surgeon, or anaesthetist ever completed anything approaching a physical examination. . . . The physical examination seems to have become an anachronism, a vestigial remnant, of clinical care. Should we mourn or celebrate the demise of the laying on of hands?¹

Horton's paean to the 'first language' of touch in clinical care came just before the outbreak of the Covid-19 (coronavirus) pandemic, which of course, increased the physical separation between clinicians and patients even further. Clinicians have become accustomed to wearing full personal protective equipment (PPE) in situations such as ward rounds where it was previously unnecessary; visits to wards have been banned; and a multitude of casual interactions between care givers and recipients have been obstructed by barriers such as screens, masks, shields and gloves. In the pages of the *BMJ*, *JAMA* and other medical journals, clinicians have bemoaned the loss of the 'human' or 'healing' touch in modern clinical care: touch, in this context, denoting not merely physical contact between clinician and patient, but also the affective dimension of caregiving. As one Indian doctor describes:

[T]he healing touch is not just limited to physical examination and prescriptions. It often included spending a few extra minutes holding the hands of an old lady, reassuring her that she would be back home to play with her grandkids, or patting the young boy to cheer him up when he misses his friends. Our nurses would regularly chat with patients during their shifts, and by the end of a patient's stay, the nurses would often know great details about their lives, ranging from their favourite food to the family dynamics at home. Even the facilities staff who came by to clean beds or pick up the garbage would often stop to recap the cricket match that India had won the previous day.²

¹ Richard Horton, 'Offline: Touch—the First Language', *The Lancet* 394, no. 10206 (12 October 2019): 1310, [https://doi.org/10.1016/S0140-6736\(19\)32280-9](https://doi.org/10.1016/S0140-6736(19)32280-9).

² 'Trupti Gilada: Medicine during Covid-19—the Healing Touch without the Human Touch', *The BMJ*, 15 June 2020, <https://blogs.bmj.com/bmj/2020/06/15/trupti-gilada-medicine-during-covid-19-the-healing-touch-without-the-human-touch/>.

Yet, as Horton's editorial suggests, Covid has accelerated a trend in contemporary medicine which was already present: the trend for clinicians to become ever more physically distanced from their patients. Even a casual reading of medical literature over the last few decades reveals many clinicians' equivalence of the sense of touch with the practice of their clinical 'art', and the 'laying on of hands' as a proxy for social and emotional connection with patients. 'Touch signifies the human nature of the predicament patient and doctor both face. Touch humanises that predicament. Touch builds trust, reassurance, and a sense of communion. Touch is about fostering a social bond of sympathy, compassion, and tenderness between two strangers.'³ The rise of telemedicine has reduced the need for physicians to conduct physical examinations, especially in primary care, while biopsies, blood tests, checklists and scans have increasingly displaced inspection, palpation, auscultation and percussion as the physician's primary diagnostic tools.⁴ Certainly, diagnosis has in many cases improved, and the socially distanced doctor is perhaps able to see more patients than before, improving throughput in an increasingly cost-conscious health care system. However, the perceived loss of 'human touch' has come to signify for many doctors not only the dehumanisation of modern health care, but also the loss of clinical skill and discernment accompanying the emergence of a more industrial, 'scientific-bureaucratic' medicine.⁵ The ritualistic 'laying on of hands' signifies not only the doctor's identity as healer—their Hippocratic inheritance—but is a symbol and instrument of their authority and power. Doctors' gripes about their loss of status, of course, is by no means a recent development; for decades, clinicians have complained about and resisted their loss of professional autonomy and subordination to systems of management and quality assurance.

It would be easy to dismiss the decline of touch in modern medicine as a mere artefact of the spread of medical technology and the emergence of a more bureaucratic, industrialised medicine where precision and speed in diagnosis and therapy are essential (and where room for the display of clinical acumen and virtuosity is reduced). But here I want to suggest another important factor: increased clinical sensitivity to the 'riskiness' of touch in the age of antimicrobial resistance, 'superbugs' and patient safety.⁶

Touch, to be sure, has always had an ambiguous quality in medicine. On the one hand, it has been associated with healing, clinical authority and human connection. On the other, it has been associated with potential contagion, intrusion and violation. The analysis of historical therapeutic

³ Horton, 'Offline'.

⁴ Paul Hyman, 'The Disappearance of the Primary Care Physical Examination—Losing Touch', *JAMA Internal Medicine* 180, no. 11 (1 November 2020): 1417, <https://doi.org/10.1001/jamainternmed.2020.3546>.

⁵ One American has relayed an anecdote about junior colleagues who increasingly opt for the 'quick' or 'cursor' physical exam: Robert E. Hirschtick, 'The Quick Physical Exam', *JAMA* 316, no. 13 (4 October 2016): 1363–64; Stephen Harrison and Bruce Wood, 'Scientific-Bureaucratic Medicine and Uk Health Policy1', *Review of Policy Research* 17, no. 4 (2000): 25–42, <https://doi.org/10.1111/j.1541-1338.2000.tb00955.x>.

⁶ See Anne Marie Rafferty, Marguerite Dupree, and Fay Bound Alberti, *Germs and Governance: The Past, Present and Future of Hospital Infection, Prevention and Control* (Manchester University Press, 2021).

practices such as gynaecological massage shows that these associations are far from obvious and straightforward⁷ Yet, ever since the work of Ignaz Semmelweis in Vienna in the nineteenth century, touch has had a particularly strong association with the spread of nosocomial (healthcare-acquired) infection (HCAI). Hand washing has long provided the foundation of hygiene in hospitals, and was among the sanitary practices promoted by Florence Nightingale (though she was sceptical towards antiseptics and the germ theory of disease, at least initially).⁸ In another sign of the connection between touch and the physician's sense of (moral) authority, ideas of contagion in the clinical context could be resisted by some physicians on the basis that 'a gentleman's hands are clean.'⁹

In the late nineteenth and early twentieth centuries, a variety of sophisticated wound dressing, hand washing and other hygienic techniques developed in hospitals, and alongside the development of new isolation hospitals for infectious diseases, forms of 'barrier' nursing also developed.¹⁰ By the mid twentieth century, the availability of new chemotherapeutics and antibiotics such as penicillin offered the tantalising prospect that hospital infection could be eliminated. A certain degree of hospital infection could be tolerated by clinicians (especially in 'risky' areas such as ICUs) on the basis that it was the inevitable 'price' of medical progress.¹¹ However, epidemics of hospital-acquired infections such as *Staphylococcus aureus*, and the emergence of antibiotic-resistant strains, such as *MRSA* and *C. difficile*, led to the 'rediscovery' of HCAI and its placement back on the policy agenda. Full-time infection control nurses were appointed to the NHS (from 1959), and there was a movement from local (ward) control of infection to central (hospital-wide) control including infection control committees and central sterile supply departments.¹² Clinicians were educated about touch as a vehicle for infection, although there is some evidence that doctors may have been more lax about aseptic practices than nurses, who could shoulder significant blame for contracting infections such as septic finger.¹³

⁷ Anders Ottosson, 'The Age of Scientific Gynaecological Masseurs. "Non-Intrusive" Male Hands, Female Intimacy, and Women's Health around 1900', *Social History of Medicine* 29, no. 4 (1 November 2016): 802–28, <https://doi.org/10.1093/shm/hkw013>; Jonathan Reinartz, 'Senses Virtual Issue Introduction', Oxford Academic, accessed 7 May 2021, https://academic.oup.com/shm/pages/senses_virtual_issue_introduction.

⁸ Florence Nightingale, *Notes on Hospitals* (Longman, Green, Longman, Roberts, and Green, 1863); Claire L. Jones, 'Septic Subjects: Infection and Occupational Illness in British Hospitals, c. 1870–1970', in *Germs and Governance*, ed. Anne Marie Rafferty, Marguerite Dupree, and Fay Bound Alberti (Manchester University Press, 2021), <https://doi.org/10.7765/9781526140791.00015>.

⁹ Virginia A. Sharpe and A. I. Faden, *Medical Harm: Historical, Conceptual, and Ethical Dimensions of Iatrogenic Illness* (Cambridge: Cambridge University Press, 1998), 154.

¹⁰ Rafferty, Dupree, and Alberti, *Germs and Governance*.

¹¹ Sharpe and Faden, *Medical Harm*; D. P. Barr, 'Hazards of Modern Diagnosis and Therapy: The Price We Pay', *Journal of the American Medical Association* 159, no. 15 (10 December 1955): 1452–56. In the 1970s, the idea of 'preventable' nosocomial infection developed, focusing on the use of specific medical devices and procedures. Sharpe and Faden, *Medical Harm*, 161.

¹² Rafferty, Dupree, and Alberti, *Germs and Governance*.

¹³ Jones, 'Septic Subjects'.

Today, HCAI are considered one of the leading causes of iatrogenic harm and a barometer of patient safety.¹⁴ HCAI are among the major causes of infection in the current pandemic.¹⁵ It is insightful that almost two centuries after Semmelweis instigated his hand disinfection procedure, educating healthcare staff about the importance of hand hygiene, and instilling the message that ‘Clean Hands Save Lives’ remains central to infection control, underpinning a patient safety alert by the National Patient Safety Agency in 2008 (Figure). The focus of these educational initiatives is on infection control at the ‘point of care’, for example, emphasising the use of alcohol-based hand rubs. Notably, emphasis is placed on the risk of infection to the practitioner as well as patient. Thus, the current trend within health care of diminishing of physical contact—of cursory physical examinations, cutting waiting lists, avoiding delayed transfers of care—not only reflects the exigencies of meeting the demands of an ageing population in the context of cost control, but perhaps reducing the risks of HCAI.



Print on the floor of Warwick General Hospital, 2018

¹⁴ Sharpe and Faden, *Medical Harm*.

¹⁵ During the first wave of the coronavirus pandemic in England, approximately 10 per cent of infections were among NHS and social care staff. <https://www.independent.co.uk/news/health/coronavirus-covid-nhs-hospital-infection-care-homes-delve-a9603781.html>



Alert

Patient Safety Alert

Second Edition 2 September 2008

NHS
National Patient
Safety Agency

Clean Hands Save Lives

This Alert applies to all providers (direct and commissioned) of NHS care in all healthcare settings in England and Wales.

Significant gains have been made in highlighting the need for best practice in hand hygiene over the last four years. The reduction in MRSA bacteraemia can in part be attributed to the concerted action across the NHS. However, to maintain this and other improvements it is vital that hand hygiene remains high on the patient safety agenda.

Improving the hand hygiene of healthcare staff at the point of patient care will reduce healthcare associated infection (HCAI). Hands are a repository for microorganisms that can cause infection. Healthcare staff in all healthcare settings have the greatest chance of transferring these as they move between patients, or different care activities for the same patient.

National and international studies continue to reinforce the fact that infection rates can be significantly reduced, by at least 15 per cent, where a multi-modal strategy has been introduced to improve hand hygiene.^{1,2,3,4} Significant progress has been made, however hand hygiene compliance still remains lower than it should be.

This Alert highlights the following key points

1. The role of hand hygiene by healthcare staff in preventing and controlling infection
2. The point of care as the crucial moment for hand hygiene
3. The appropriate placement of alcohol handrub products
4. Which hand hygiene products to use and when
5. The current recognised standard for hand hygiene products
6. Management of risks including ingestion, storage and skin irritation

Action for the NHS by 31 March 2009

All providers of NHS care in England and Wales will:

- > Undertake an audit to review current risk management strategies including:
 - the placement, accessibility and suitability of all hand hygiene products, including handwash basins and handrub dispensers, to ensure healthcare staff are able to undertake hand hygiene at the point of care
 - all hand hygiene policies, processes and programmes to ensure they prioritise hand hygiene at the point of care
- > Develop and implement an action plan to address the issues identified in the audit.

worth repeating

This Alert is based on the first hand hygiene Alert (Alert number 4) issued by the NPSA in 2004 and is revised in line with current best practice guidelines in 2008.

NPSA Patient Safety Alert, 2008