

The Review

Touch in the consultation

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,¹ but touch cannot be understood purely in terms of proprioceptors, dorsal root ganglia, and the like. Modern medicine need 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.² 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.³

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 skilfully 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 feel that it is acceptable to be touched by their GP in a reassuring or comforting manner; and other parts of the body where patients feel it is appropriate to be touched by their GP for comfort. These areas were identified through clinical experience, discussion with colleagues, and from a review and analysis of the literature. I hypothesised

that female patients would probably find the use of touch more comforting than male patients and that they would probably derive more comfort from female GPs than male GPs, and that a more distal position on the arm was likely to be more acceptable for the GP to touch. I also hypothesised that a position closer to the midline and on the front of the body would be less acceptable as an alternative.

Between January and March 2010 the receptionists in our three-partner GP training practice (with a list size of approximately 9600 patients) and I distributed 220 questionnaires: 195 were returned. More females than males under 60 years of age responded, with similar sex proportions in the over-60s. There was no patient-identifying information on the questionnaires and the data were stored on encrypted files.

The main findings of the survey are summarised in Table 1, which shows the percentages of male and female patients who said that they would be comforted by their GP touching them in a reassuring way if they were to become upset. Most patients would welcome their doctor's touch, with slightly more female than male patients agreeing to this, 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

Table 1. Main findings

	Touch by male GP, % (n/N)	Touch by female GP, % (n/N)
Male patients that felt comforted	75 (56/75)	77 (58/75)
Female patients that felt comforted	83 (100/120)	92 (110/120)
Overall	80 (156/195)	86 (168/195)

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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, and it is hoped that this study may stimulate further modes of clinical research and discussion. My preliminary findings of the use of touch in comforting patients in general practice suggest that touch is indeed a 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 contribute to the strengthening of doctor-patient relationships.

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Provenance

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REFERENCES

1. Kennedy DP, Gläscher J, Tyszka JM, Adolphs R. Personal space regulation by the human amygdala. *Nat Neurosci* 2009; **12**: 1226–1227.
2. Gadow S. Touch and technology: two paradigms of patient care. *J Religion Health* 1984; **23**: 63–69.
3. Leder D. *The body in medical thought and practice*. Dordrecht: Kluwer Academic Publishers, 1992.

Word cloud analysis of the *BJGP*

A 'word cloud' is a visual representation of word frequency. The more commonly the term appears within the text being analysed, the larger the word appears in the image generated. Word clouds are increasingly being employed as a simple tool to identify the focus of written material. They have been used in politics, business and education, for example, to visualise the content of political speeches. In the Health Board that I support, word clouds have been applied to analyse the content of Board committee papers to see whether sufficient attention is being given to the core business of the organisation.

Word clouds should be interpreted with certain caveats. They often fail to group words that have the same or similar meaning,¹ for example, 'GP' and 'GPs' or 'Research' and 'research.' As they tend to focus only on single word frequency, they also do not identify phrases, reducing context.¹

A word cloud analysis of the entire content of the *British Journal of General Practice* from 2011, constituting 600 000 words, was conducted using the online programme Wordle (<http://www.wordle.net/>). A maximum word limit of 100 was set. Common English words were removed. The image generated can be seen on the cover of this Journal.

According to its editorial policy, the *BJGP* is 'an international journal publishing articles of interest to primary care clinicians, researchers, and educators worldwide. Priority is given to research articles asking questions of direct relevance to patient care.'²

The word cloud generated from the analysis was measured against the stated editorial policy of the Journal above. Firstly, it can be seen that the two most prominent words highlighted are 'care' and 'patients'. This finding does conform to the aim of the Journal to focus on these areas. In terms of the Journal's concentration on research articles, the words 'study' and 'research' as major terms both appear, again reflecting well the Journal's policy. The target audience of the Journal is given as 'primary care clinicians, researchers and educators worldwide';² the terms 'GP/s', 'primary', 'general', 'practice' and 'clinical' do emerge in the analysis. However, the word 'education' fails to materialise, although 'training' does appear, but only as a lower

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order term. In view of the international aim of the Journal, the analysis seems to suggest that its content is perhaps too weighted towards the home audience, with 'UK', 'London', and 'NHS' being the only geographic terms to appear in the word cloud.

Of interest, the medical conditions that figure most prominently in the analysis are 'cancer' and 'depression'. The full extent of the patient journey is revealed, with 'symptoms', 'diagnosis', and 'treatment' all included. The words 'time' and 'years' are visible, perhaps reflecting the long-term nature of the GP-patient relationship. 'Quality' appears as a minor term, which is a surprise, given its importance in patient care; 'risk' appears larger. In terms of my own speciality, public health medicine, the words 'social', 'screening', 'population', and 'need' all make an appearance, but only as minor terms. In addition, there is no mention of 'equity' or 'prevention'.

In conclusion, a word cloud analysis of the Journal has shown that it seems to have largely fulfilled its stated aim of ensuring that priority is given to research articles of direct relevance to patient care for primary care clinicians. However, it should, perhaps, reflect on whether it needs to become more international in outlook. Furthermore, the analysis has reflected the very diverse nature of primary care practice.

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REFERENCES

1. Ramsden A, Bate A. *Using word clouds in teaching and learning*. Documentation. University of Bath, 2008. <http://opus.bath.ac.uk/474/1/using%2520word%2520clouds%2520in%2520teaching%2520and%2520learning.pdf> (accessed 7 Feb 2012).
2. British Journal of General Practice. Information for authors: editorial policy. http://www.rcgp.org.uk/brjgenpract/information/for_authors.aspx (accessed 7 Feb 2012).