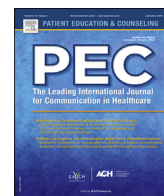




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Correspondence

COVID-19 and touch in medical encounters



Before the Covid-19 pandemic changed the healthcare context, touching patients belonged to the unquestioned daily activities for many healthcare providers. The standard professional tasks and responsibilities of doctors involve clinical examinations. Physiotherapists use their hands to treat patients and nurses touch patients while caring for them. Researchers have studied the meaning of touch during this patient-provider interaction in many ways. Observational, descriptive studies show us how touching occurs and how people react to it [1]. Qualitative research explores experiences both from patients and professionals about touching and being touched (e.g., [2]). Furthermore, others highlight the need to train healthcare providers in the art of touch and make suggestions on how to achieve this [3]. These study results exemplify that touch in healthcare is an essential aspect of care delivery, influencing the patient-provider relationship and the perceived quality of care. Touch is a complex concept as confirmed by a recent meta-ethnography describing that touch 'is caring, exercises power, and demands safe space' [4]. Others have made efforts to clarify the concept of touch in caring and in healthcare, revealing the multidimensionality of touch and advocating the need for a holistic view to the concept [5,6]. Many classifications have been put forward distinguishing procedural touch from communicative touch, instrumental from expressive touch, functional from unnecessary touch, but all acknowledge the importance of touch as a means of communication [1]. It has been argued that touch is a language in its own right, that does not always easily translate into words [7]. Touch contact can be deeper than any verbal communication and is informed by presence, intention and congruence between other forms of communication [8]. The accuracy of showing and interpreting emotions through touch has been explored and confirmed in experimental settings [9,10].

In clinical consultations, doctor-patient interactions usually run along scripts which are historically, socially, culturally, economically and politically situated. Given the routine of their practices, doctors and patients commonly know how to interact during the various phases of a consultation in the doctor's consultation room [11]. During the "front stage" of this encounter, i.e. the consultation itself, the patient's body is the focus of discursive and bodily interaction. Here, research has shown how "touch" initiated by caregivers can generate trust, a sense of safety and comfort [12]. In certain instances, "touch becomes an indicator for the quality and the perception of certain forms of care" [13 p. 161]. Hunter and Struve advocate that touch has the propensity to establish, maintain and deepen healthcare relationships [14].

Following the front stage, there is also the "back stage" context, examples of which are the encounters in the waiting room, or at the corridor towards the exit, when the doctor accompanies the patient to leave the venue (the stage). In the "back stage" context, people's behaviour and its meaning can differ from that at the "front stage". In these "back stage" moments of doctor-patient encounters, the appropriateness of tactile contact is far from straightforward. Nonetheless, recent ethnographic research on "back stage" interactions between doctors and patients emphasizes the importance of a GP's "compassionate touch", which can be understood by patients as "recognition, respect, care, and solidarity" [4,15]. The body of evidence on the use, meaning and impact of this back stage touch is far less compared to the research on touch during the front stage; with surveys and descriptive studies exploring the perceptions and preferences of touch in the back stage. Overall these studies describe how touch in the back stage is occurring on an almost daily basis and is generally experienced as something beneficial to patients. Cocksedge, for instance categorizes physicians according to the frequency of the touching they perform (for example handshakes or a comforting pat on the arm) [16]. Some physicians are deliberately using this kind of touch very frequently because they consider it to be supportive and comforting, while others are trying to follow the patient's pace regarding touch [16]. A third category limits touch to the occasional handshake and explains hesitance as a result of fear of being misinterpreted.

Similarly patient preferences on being touched have been investigated according to gender [17,18], ethnicity [19,20], age and socio-economic status [20,21], the body part they prefer (not) to be touched [17,18], the physician's medical specialty [22,23] and during specific encounters like medical error disclosure [24]. In general, patients who are female, elderly, from lower socio-economic status and those from Mediterranean cultures are more open to physical contact. These general findings need to be interpreted within the nuanced context of the consultation, for example considering the gender of the physician (more accepted from female physicians), duration of the relationship (more frequent with general practitioners) and disease (generally used more in palliative care). The conclusion of these studies suggested preferences to touch varied however touch was welcomed by most patients, if their preferences were taken into account.

Physicians' attitudes towards back stage touch has equally been studied in a descriptive way, revealing the explicit and intentional use of touch by physicians to support patient care. [25,26]. This was equally the case with doctors from specialities such as psychiatry, where physical examinations and physical touch is more likely to be absent. [25]. These descriptive studies on the occurrence of and preferences towards back stage touch are

complemented by a few studies on its impact, for instance the effect of touch on patients' experiences of time spent in the waiting room [27] and the effect of touch on patients' adherence to medication [28]. The scarce literature on the meaning and the effects of back stage touch suggests that it has mostly positive effects, like generating comfort or enhancing the trust in the physician. What is currently lacking is sound research on the impact of this back stage touch on the quality of healthcare delivery, on health related outcomes for the patients as well as on the physicians' professional wellbeing.

The need for further research on back stage touch becomes apparent when touch is being compromised, as evidenced during the COVID-19 pandemic. Of course, the front stage touch remains. Doctors still examine patients, physiotherapists continue to treat and nurses to take care, although in different and often contentious circumstances. However, the back stage touch seemingly disappeared. Governmental restrictions and regulations, aimed at slowing down the spread of the virus have had a major impact on the way health care has been delivered since the start of the COVID-19 outbreak, resulting in a significant reluctance to employ back stage touch as an immediate consequence. How do clinicians and patients experience the absence of the non-functional and back stage touch, creating an interpersonal distance neither of them has asked for? We hypothesize that this experience might impact on the quality of care and on the professional's wellbeing. A recent scoping review illustrates the physical and mental health impact of COVID-19 on healthcare workers [29]. Many diverse factors contributed to the diminishing of the professional wellbeing, like the risk of becoming infected or the long working hours. The relationship with the patient and the difficulties to preserve this relationship (including the use of touch as being relationship supportive) did not seem to have been the focus of this research. Studies on the impact of the loss of back stage touch on patients' wellbeing or on the patient-physician relationship could similarly not be found.

To better understand the impact of the significant reduction of back stage touch, we need a deeper understanding of the meanings and values of this nonverbal communication tool within the clinician's repertoire of interpersonal skills. Overall, the debates and conversations about the use of touch denote that relationships in healthcare are complex. Humans are multi-faceted and any communication including touch can be multi-layered in meaning. Overall, touch is generally considered to be 'good' and appropriate when some rules are being taken into account, although these rules are not entirely clear. We are currently experiencing how healthcare policies and societal norms influence the use, and consequently the impact, of touch during medical encounters. As a result, to move beyond the level of descriptive studies that have been conducted up until now, we need to initiate transdisciplinary research collaborations involving researchers, methodologies and theoretical frameworks from medicine, philosophy, psychology, sociology and anthropology. Such research is urgently needed to anticipate the effects of the absence of touch for both patients and clinicians, and also to understand and teach (future) healthcare providers on how to use it. We need to map the different types of back stage touch and their characteristics: who, what, when, where and why? We need to further explore patients' and providers' experiences of this kind of touch and we need to understand the relationships between back stage touch with health related outcome measures for patients. If we fail to underpin this important communication tool with sound research results, we hinder our ability to understand the meaning of its disappearance and its impact on the quality of care. We need this

knowledge to be able to compensate with other ways of interacting in order to guarantee high quality care delivery.

Author statement

PP and AR conceived the idea. All authors contributed equally to the writing of the manuscript.

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