A Touch Of Sense

Patients and physicians connect through touch and trust.

BY ABRAHAM VERGHESE

LAST FALL I CAME HOME FROM A LONG DAY at the hospital, fell onto the sofa, put my feet up, and switched on the television. Tristan, my eleven-year-old son, soon plopped down next to me and threw his leg over mine. As we watched television together, his hand began to idly probe my ear, jiggle my thyroid cartilage (he'd call it my Adam's apple), tug on my nose, and ruffle my hair. He fixed his eyes on the screen's images, seemingly unaware of the activities of his fingers. It was as if my body were only an extension of his. I cherish such times with him, knowing that all too soon he will be like his older brothers (now in their twenties) who find it awkward to touch Dad other than for money. I'm the one who reaches for them, drapes my arm around their shoulders in attempts to lure them back into a physical intimacy that they feel they have outgrown. Tristan's probing closeness reminded me of a subject that I've been thinking about a great deal in connection to my work teaching medical students and residents how to examine the body, and that is the sense of touch.

As it turned out, Tristan and I happened to be watching touch of another kind on the nightly news that evening; first one, then the other presidential hopeful was "pressing the flesh." With my son's hands on me and mine on him, I saw this familiar scene anew, as if I were an anthropologist who had stumbled on a rare tribal ritual. A thicket of hands extended out urgently to the candidates (but to no one else—certainly not to their own neighbors); the candidates tried to clasp as many of those outstretched limbs as they could. The crowds appeared hungry, as if intent on taking something tangible from the candidates. The line separating order from disorder, glad-handing from manhandling, was a thin one. Those who couldn't shake the candidates' hands satisfied themselves (if they were close enough) by touching backs or arms or, in one instance, unintentionally, a head. From my anthropologic perspective, this seemed fantastic: strangers jockeying to touch someone they had never met. I wondered how the candidates felt about this. What did touching mean? Were they impinged upon? Thrilled? Tickled?

Abraham Verghese is a physician, professor, and senior associate chair for the Theory and Practice of Medicine at Stanford University School of Medicine in California. He was the founding director of the Center for Medical Humanities and Ethics at the University of Texas Health Science Center, San Antonio, where he is now an adjunct professor. Verghese is the author of My Own Country *(Vintage Books, 1994),* The Tennis Partner *(HarperCollins, 1998), and* Cutting for Stone *(Alfred A. Knopf, 2009), as well as short stories and essays. He lives in Palo Alto, California.*

DOI 10.1377/hlthaff.28.4.1177

Tristan is very ticklish. A mere wiggle of my fingers in his direction is enough to make him writhe and laugh. The *thought* is as good as the action. I've tricked him into thinking that I lack tickle spots. I maneuver to hide these trigger points from him, and, when he gets too close, I employ great self-discipline to keep a straight face. It fascinates us both that he can touch his own tickle spots with impunity, while the lightest touch from me triggers hysterics. And if a stranger tried to touch him he would see that as a frightening assault, no laughing matter.

What could be the teleology of a special sense that allows so many interpretations? It's a question that occupied Charles Darwin, among others. Clearly, at one level, touch is simply protective—it warns us of contact. And if it's contact with our own self, it's not ticklish; if it's contact by a friend, it can be ticklish. Freud pointed out that the tickler gets a payoff from this role: tickling combines aggression and closeness, while the person being tickled relinquishes some dominion over his or her body. The laughter suggests consent, but that is belied by the writhing and wriggling movements to escape. And, of course, if the person touching has no permission to touch, then it's not funny at all.

"For the past two decades I've felt that in the United States we touch our patients less and less: the physical exam, the skilled bedside examination of the patient, has diminished to where it is pure farce."

Later that evening, I looked up the word "touch" in the dictionary. I was surprised to find two pages of meanings and uses. We talk about how we are "touched" by a piece of literature or music, implying that it penetrated our defenses, but happily so. Many uses of the word have to do with control: "losing touch"; "getting back in touch with oneself"; "touch of madness"; "touch a nerve," to name a few. That night I did more reading and made a few notes. By the time I went to bed, I felt sheepish to have come to this simplest of insights: *Touch is so much more than touch*.

The Bedside Exam

THAT TOUCH-IS-SO-MUCH-MORE-THAN-TOUCH is a useful idea for me to come to because it gives me a new weapon in a long skirmish. For the past two decades I've felt that in the United States we touch our patients less and less: the physical exam, the skilled bedside examination of the patient, has diminished to where it is pure farce. "Cranial nerves two through twelve intact" the physician's note reads, or "No hepatosplenomegaly" or "Reflexes intact"—but don't bet on it. As one watches residents at work, the technique one observes is poor and rarely allows for a valid conclusion. One student wrote to me recently, "Honestly, I feel when I am doing the physical that I am just going through the motions." The prevalent belief is that it's hardly worthwhile examining the patient, as none of

these findings matter.

Although our medical students cough up big money in their first year to purchase stethoscopes, tendon hammers, ophthalmoscopes, otoscopes, and tuning forks, and although they learn the steps of the examination and practice on each other for two years, when they actually arrive on the wards in their third year, they're in for a surprise. They find that the real action in the hospital revolves around the computer and getting imaging results, getting consults called in and lab results back. The only instrument being carried is the stethoscope, which is more a class badge than a diagnostic aid. An anthropologist walking through our hospitals in America wouldn't be blamed for concluding (on the basis of where physicians spend the most time) that the real patient is in the computer, while the individual in the bed is a mere placeholder for the real patient.

"An anthropologist walking through our hospitals in America wouldn't be blamed for concluding that the real patient is in the computer, while the individual in the bed is a mere placeholder."

Because MRIs, angiograms, and PET scans give us incredible pictures of the body's innards, they have created the illusion that there's no other way to "see" the body. For that reason, when a skilled clinician demonstrates a slew of findings on a body and then makes inferences that link the findings into a cogent story, it always seems to astound students. It's no accident that Sir Arthur Conan Doyle's famous fictional sleuth was modeled after his clinical professor, the legendary Joseph Bell. In one instance cited by Conan Doyle, Bell deduced that a woman came from Burntisland, that she had crossed that morning in the ferry, that she had set out with two children but dropped one child off along the way, that she had taken a shortcut through Inveleith Row and the Botanical Gardens, and that she worked in the linoleum factories—all this from astute observation and deduction even before the patient sat down to be examined. (The curious reader can see this dialogue and the explanation in the 18 August 1956 issue of the *Lancet*.)

Doctors of Bell's era, including his North American contemporary, Sir William Osler, were by all accounts phenomenal at the bedside. Yet Osler, for example, had to perform more than a hundred autopsies a year to make the kinds of correlations we can make instantly these days with echocardiograms, angiograms, CTs, and MRIs. Michael Phelps, the Olympian who shattered all the swimming records in Beijing in 2008, was the beneficiary of advances in physiology, nutrition, and training that allowed his performance to eclipse that of swimmers of half a century ago. Similarly, we who are able to not only touch but, soon thereafter, to see and confirm with imaging should be a hundred times more discerning than Osler and Bell at the bedside; our sensory instruments—touch, sight, hearing, smell—should be honed to precision with the wealth of technologic feedback that tells us when we were right and when we were wrong. That's what *should* have happened, but, alas,

the opposite is true. We've regressed to the Dark Ages, to the days of the barber surgeons where no attempt was made at seeing into the body (and no method was known) so that whatever ailed you, the treatment was bleeding, cupping, or purgatives.

But that evening, in front of the television with my son, I recognized a new dimension to the bedside exam, one that I'd overlooked. In advocating just the diagnostic value of the physical exam, just the evidence-based-medicine kind or argument about the utility of finding the spleen or hearing a third heart sound, I'd missed what was really important: touch. The physical exam is really about one individual granting permission to another individual to touch his or her unclothed body, to probe the most ticklish and private places. The exam then is about trust, about a sacred privilege. I can recall occasions when my visit with a difficult or aggrieved patient, or with a garrulous and hypochondriac patient, changed course as I performed a detailed examination. On those occasions, I had a sense that the exam had flowed, it had become almost a dance, one in which the patient was an active participant, and that it had quieted and reassured my patient, the exam itself bringing about this change. Indeed, in those moments, I became aware that I'd changed, too, as though both of us—doctor and patient—had entered some sacred space by virtue of this ritual and had been transformed.

It's telling that when patients complain about us, about the physicians who saw them, one often hears the expressions, "He never touched me!" or "She never laid a finger on me!" No matter what we might think about the diagnostic utility of the physical exam, it seems clear that the trust the patient places in us by allowing our touch hasn't changed over the centuries; the patient doesn't take this lightly. We are, therefore, obliged to touch them in the most skilled and thoughtful way we can. It cannot be a hollow gesture or farce.

A Healing Ritual And Bond

Ritual might be the best way to argue for the importance of the intangible aspects of the bedside exam. The wedding ritual, for example, is a formalized, socially prescribed, and intensely symbolic behavior; it's deeply meaningful and transformative, and it reenacts mythology. The bedside exam, when viewed as ritual, is a reenactment of a healing scene that has played out through recorded history: one individual with expertise, anointed by society and a guild in that role, attempts to relieve the suffering of another. If you find this idea of ritual hard to swallow, just look at the trappings of ritual that surround us as physicians: the white coat, the stethoscope, the headlight, the diplomas on the wall, the specialized language, the plaques and other tchotchkes in our office—these are the juju beads, animal skulls, healing candles, and joss-stick equivalents of traditional healers. We are steeped in ritual...and yet it seems we doctors feel terribly miscast in our roles of shaman or healer.

The patient has no such confusion about his or her role: the patient expects to be examined. When we are sick, we become infantilized; we seek the reassuring touch of the surrogate father or mother, the only ones who can touch us with impunity and bring about laughter and comfort. A careful exam invokes the mythic rites of priest and confessant, of saint and disciple, of healer and sufferer. In these modern times, when medical care is so fractured, a thorough exam conveys attentiveness in addition to providing comfort and reassurance. At the end of this ritual, physician and patient are no longer strangers but are bonded through touch, and yet the ritual is fully connected with the science and knowledge of our time. That bond moves the patient toward healing—not just of the body, but of the psychic wound that accompanies physical illness. I don't want to imply that the bedside exam is only about ritual; for me and other physicians of a certain age and training, it remains an invaluable diagnostic tool, one that puts us a day or two ahead of those who have to rely on imaging and other tests before they can make a move. But it's nice to realize what else the exam does.

In the fiscally challenged days that lie ahead of us, I believe efforts to rein in health care costs will surely bring more scrutiny to diagnostic testing, not to mention to limitations on expensive therapy. When we actually have to *think* about how much a test costs and who will pay, sound bedside skills become an important way to say with some confidence, for example, that an echocardiogram isn't needed for a particular heart murmur. The skilled and prudent clinician will be as important to the future of American medical practice as the hybrid car will be to the American highway.

"The skill (or clumsiness) in handling a tendon hammer should matter as much as being able to pick out the answer in a multiple-choice question about the meaning of absent or hyperactive tendon reflexes."

The problem is, though, that nobody owns this mission within medical education. There is clear responsibility at my school and at others for the introductory course that teaches the first- and second-year medical students physical diagnosis (often practicing on each other or on standardized-patient actors). But then it stops. No department is charged with seeing to it that *clinical* students develop the ability to apply and refine necessary bedside diagnostic skills on real patients. Highlighting clinical skill building by specifying responsibility for teaching and testing these competencies throughout medical school requires a designated department responsible for making sure that students' bedside capabilities are polished into well-honed rituals. Of course, this will only matter if we focus on these same skills with our residents and chief residents, and with our faculty. I mean that the skill (or clumsiness) in handling a tendon hammer should matter as much as being able to pick out the answer in a multiple-choice question about the meaning of absent or hyperactive tendon reflexes.

What It Means

THERE IS AN INDELIBLE SCENE THAT COMES BACK to me often and without invitation. But in recalling it as I write this, I'm no longer distressed; it has taken all these years to find reassurance in this memory. It harks back to the time when I made regular visits to the sickbeds of patients dying with AIDS in the era before modern therapy. I remember the reluctance, the sense of failure that enveloped me when I went by the room on rounds or paid a home visit. I never knew what to do, what to say. Out of that awkwardness and embarrassment, I'd fall back into the only role I knew to play at the bedside: I'd feel the pulse, then gently pull down the eyelid to see the color of the mucous membrane, then examine the tongue, sound out the hollow chest with the time-honored technique of percussion, listen to the lungs, then feel the abdomen—my ritual. I recall so many pairs of eyes of so many people—all of them now long dead, but their names still vivid, fresh on my tongue—huge haunted eyes in hollowed-out sockets, staring up at me as I performed my exam. And when I was finished, I'd take my leave, and the next day I'd do it again.

I recall one patient who was, at that point, no more than a skeleton encased in shrinking skin, unable to speak, his mouth crusted with candida that was resistant to the usual medications. When he saw me on what turned out to be his last hours on earth, his hands moved as in slow motion, and as I wondered what he was up to, his stick fingers made their way up to his pajama shirt, fumbling with his buttons. I realized that he was wanting to expose his wicker-basket chest to me: it was an offering, an invitation. I didn't decline. I percussed, palpated, and auscultated. I think he surely must have known by then that it was vital for me, just as it seemed necessary for him. Neither of us could skip this ritual, which had nothing to do with detecting rales in his lungs, or finding the gallop rhythm of heart failure. No, this ritual was about the one message that physicians have needed to convey to their patients, although God knows, of late, in our hubris we seem to have forgotten, we seem to have drifted away, as if with the explosion of knowledge, the whole human genome mapped out at our feet, we are lulled into forgetting that the ritual is cathartic to the physician and necessary for the patient, forgetting that the ritual has meaning and a singular message to convey to the patient. And the message, which I didn't fully understand then, even as I delivered it, and which I understand better now, is this: *I will always, always be there, I will see you through this, I will never abandon you, I will be with you through the end.*

The author thanks Ralph Horwitz and Jerome Kassirer for helpful discussions that informed this essay.