TO TOUCH OR NOT TO TOUCH: COMMUNICATION BETWEEN PHYSICIAN AND PATIENT – A PILOT STUDY

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ABSTRACT

In this article the act of touch as a form of nonverbal communication, which constitutes part of the "unspoken" or "silent sound" message between the doctor and patient, is investigated. Communication researchers often maintain that nonverbal communication carries vastly more weight than the verbal message content. International research indicate that patients feel positive about the inherent and constructive potential meaning conveyed by a doctor or health care professional who touches them in a supportive and empathic manner. Sometimes words are not sufficient to convey feelings, and the act of touch can fulfill this gap. A pilot study done in Bloemfontein under hospitalised patients confirms that patients feel that empathic touching can contribute to answering emotional needs, thus facilitating the total healing process and enabling the patient to cope better with sickness and possible hospitalisation. The tertiary training of doctors mostly account for interpretation of patients' verbal responses, while underplaying the patient's nonverbal behaviour. Verbal and nonverbal communication skills should be seen as inseparable at all times, and the sooner these skills can be acquired by physicians, the sooner will the quality of the doctor-patient-relationship improve in our communities.

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INTRODUCTION

Touch is a primary human need, and a very potent and powerful method of communication.

Similarly to verbal (with words) communication, nonverbal communication has as its chief purpose the sharing of meaning. In fact, all nonverbal actions, such as touch, can be conducted with a certain purpose, message or meaning.

Touch serves as a means to convey personal appreciation, warmth and comfort as well as "accommodation" from the doctor to the patient. It may also convey a message of dominance or submission, or it can be applied with the purpose of encouraging or satisfying sexual desire. Unarguably, the doctor and patient may differ in their perception, comprehension and interpretation of the meaning of touch (Legget 1994:488). However, Henderson (1981:77) states that "...tactile communication has decreased in the doctor-patient relationship and this is a source of dissatisfaction for patients. Instrumentation has minimised touch of the patient by the physician"

It is difficult to envisage the medical discipline without the act of touch - how else will a medical examination be conducted? However the manner in which, and the frequency with which, a doctor touches the patient will certainly convey a message about the doctor's feelings about the patient and his/her disease (Blondis & Jackson 1977:6).

The positive effects of touch are potentially so powerful that it has been viewed throughout the history of medicine as essential to the process of healing and cure. Different religious groups believe that the laying-on of hands are centrally important in the healing of sick people, whereas the king's touch was seen as an instant cure for sickness during the Middle Ages!

Touch is such a unique and critical part of the practice of medicine that a "hands on experience" is often referred to during the training of doctors. As we shall see below, studies have proved that patients who were more frequently being touched by nursing staff became more talkative and displayed more positive attitudes toward their illness and hospital experiences.

In the physician-patient-relationship, the consultation can be grouped into several phases or steps. The doctor should firstly devote time to a recording of medical history and particulars. This should be followed by a physical examination during which touch by the doctor is not

only essential, but also critically important to the outcome of the consultation. Lastly the doctor comes to a diagnosis and prescribes therapy and/or treatment for the illness.

IMPORTANCE AND AIM OF THE STUDY

Montagu (1971:9) views the human skin, secondary to the brain, as man's most sensitive organ system, and touch therefore can be seen as the mother of all senses. Even Aristotle remarked on the skin being the most fundamental of all our senses (Montagu 1971:9; Blondis & Jackson 1977:6).

The use and value of non-sexual touch have become neglected, and even abolished outside the context of intimate relationships. "It is perhaps rather sad that you have to be old and dying before the doctor can hold your hand without the contact being open to misinterpretation!"(Montagu 1971:4).

The medical profession primarily aims to facilitate the healing and cure of sick people. The sick person's levels are inhibited on cognitive, affective and functional levels, and it can result in sickness having a severely disabling, isolating and paralysing effect. Should the act of touching be applied in a positive way in order to address the sick person's needs, the total healing process can possibly be facilitated. The message transfer and relationship between physician and patient can consequently become more meaningful, particularly in the case of terminally-ill patients, and physically as well as mentally disabled people, who are not being touched regularly as a result of stigmatising. In the case of patients experiencing touch as confirming and supporting, doctors should be sensitised as early as possible to be alert to this form of communication, preferably during tertiary training.

The possible outcomes and results of this study could be crucially important for the general practitioner in view of the fact that touch, as a code of nonverbal communication, can be learned or unlearned relatively easy, depending on whether it is experienced positively or negatively by the patient within the context of the doctor-patient-relationship. If it can serve a constructive, positive purpose, all doctors should prioritise this aspect to increase and optimise effectiveness and success of communication with their "clients", just as any manager would try to deliver the best service to his clients.

Therefore this study aims to examine the area of touch as nonverbal code of communication in the process of message transfer between the general physician and his or her patients. Among the issues which need to be explored, are the following: does the patient and physician attach any meaning to the act of touch; and does the patient have a need for touch? It could thus possibly be established whether touch signifies elements of healing and care for the patient.

Patients' perceptions of their physicians are also analysed in order to verify whether more emphatic and "humane"doctors are placing more emphasis on touch with the explicit purpose to contribute to healing and support for the patient. Other matters which are addressed, include the different meanings which can be attached to touch as a cultural form of nonverbal communication and, if positive, where patients would prefer to be touched by their physicians.

MAJOR STUDIES ON TOUCH

With reference to existing literature, few studies have been conducted. However, a study of Agulera (1974) found that when nursing staff touched patients more than it was necessary, patients became more talkative and had a more positive perception of health care personnel. (Eisenberg, Falconer & Sutkin 1980:11).

Pattison was the first researcher conducting studies on the impact of touch during counselling and therapeutic sessions (Eisenberg, Falconer & Sutkin 1980). Those clients who were being touched more frequently, also explored the area of self-touch increasingly, and he maintains that tactile communication should receive more attention in view of the inherent potential of creating an atmosphere of acceptance and caring. His studies mainly centred around three issues:

(1) whether clients who are being touched more, also apply more self-explorative touching;

(2) whether those therapists and counsellors who touch patients frequently, were perceived differently than non-touching persons ; and

(3) whether therapists feel differently toward those patients whom they have touched more frequently (Autton 1989:48). A strong correlation was found between touch and self-disclosure, and is confirmed by Jourard (1964) who states that therapists certainly

have better rapport with those patients whom they have touched.

Suiter and Goodyear (in Autton 1989:92) used three bodily locations or levels of touch: the patient's shoulder, hand, and a semi-embrace. In another study by Stockwell and Dye (also in Autton 1989:60), the effect of therapists' touch were tested in their clients' evaluation of their degree of counselling, without showing a positive relation.

In a study done on depressed patients, Bacorn and Dixon (in Autton 1989:93) endeavoured to determine the effect of tactile communication on the client's perception of the therapist. Each person was touched four times, and nonverbal messages were supported by suitable verbal messages. Most respondents perceived the touch by the counsellor as an expression of friendliness, warmth and care, and the word "understanding"was used frequently to define the act of touch.

Research indicates that illness mostly begins when a person loses life-meaning and a vision of the future and love. In such cases physical touch can increase feelings of self-worth in a patient, as if he or she is a person who is worthy to be touched by other people. This can improve his or her own identity and self-healing (Jourard 1964). Even a platonic handshake can help sick patients, who may feel alienated from their environment as a result of the disease and symptoms, to experience themselves as part of their surroundings, says Jourard (*ibid.*). The majority of studies are in agreement that the act of touch can be facilitating and therapeutic, particularly in adults and children who have been abused physically and emotionally.

Touch as form of nonverbal communication between doctor and patient

Although touch does not form an integral part of the doctor-patient-interview, it can be applied effectively in order to communicate warmth and understanding to the patient. However, taboos in the majority of cultures are very explicit and strict, particularly with regard to sexual connotations. As a result, physical contact is very often avoided, with touch as form of nonverbal communication consequently being neglected (Von Raffler-Engel 198:143).

In any doctor's surgery, the need for a physical examination as part of the diagnosis opens up the possibilities of exploring touch as

communication medium, which can also fulfill a therapeutic function in carrying a message of support and comfort to the patient.

A primary distinction should be made between functional touch as it occurs between doctor and patient during the physical examination (that is measuring blood pressure, injections, and manually searching for pain and pressure areas), and therapeutic touch aimed at comforting and calming the patient. In a study conducted by Larsen and Smith in 1981 (Dickson, Hargie & Morrow 1993:67), it was found that whenever doctors frequently touched their new patients during first consultations, the patients were less pleased with this doctor and also did not understand the doctor's communication. (This study focused on first consultations only).

Touch can be an extremely powerful instrument bonding humans, but it cannot be used without proper consideration. Furthermore, although touch can be an essential component of diagnoses and healing in the surgery, it must be remembered that it can be misconstrued by the patient, particularly when it does not occur spontaneously from the side of the communicator. Doctors must thus ascertain why they want to use touch as a medium of communication (Linklater & MacDougall 1993:2569).

The total issue of touch is moreover complicated by those doctors desperate to convey comfort and reassurance to severely ill or dying patients. Touch can be critically important to that patient who finds himself in a crisis, but the physician must ensure that the patients' needs and feelings enjoy primary importance, and he/she must also be able to verify and define the need for touch. A study by Gardener, Fuller and Mensch (1973:1077) suggests that physicians who touch patients frequently, are more likely to end up as abusers. It should thus be quite clear that the context and content of touch can be used as a criterium of predicted sexual transgressions on the side of the doctor (Linklater & McDougall 1993:2569).

In the medical context, Northouse and Northouse (1992:140) adapted a study by Heslin (1974) according to which messages conveyed by types of touch have been categorised as follows: functional-professional; social-polite; friendship-warmth; love-intimacy; and sexual arousal. With reference to meaning, it is crucially important that touch conveys the professional content of the act.

An applicable illustration would be the context of the gynecological examination, which can be a potentially uncomfortable experience for almost all women. The explicit message in this case should thus be

one of necessity - the act of touching being inevitable to the outcome of the situation - and not that of touch occurring in the context of conversation, or assault or experiments, but something which has to be done. Such patients should never doubt the central message, namely that the pelvic area is seen as any other bodily part in the medical context, and that no private and sexual connotations are involved (Stoeckle 1987:218).

Calnan (1983:2) states explicitly that the first contact from the doctor's side with the patient should be a smile, the second an act of touch, and thirdly an inviting question such as "what can I do for you?"By means of the senses of sight, touch and speech during the formal greeting episode, a patient can form a perception of a warm, empathic doctor. Physical contact is important: a hand touching the patient's arm or shoulder confirms and emphasises emotional contact, resulting in the patient feeling reassured and not alone.

Feedback can also be given by merely touching the communicator, and simultaneously conveys attention and empathy. An attentive doctor can likewise detect hidden feelings in the patients nonverbal communication, while it can also disclose much more than that which the patient consciously allows. Pendleton (1984:14) states unequivocally that "... when patients describe their symptoms, their gestures may be more accurate than the words they use..."

It is argued that when we are being touched, or touch another person, we leave a far more permanent impression than mere words. When touch occurs, it can be understood that the process of attraction and bonding overcomes the natural human inclination of people to defend his/her personal space. Touching eliminates space between people - a matter of zero-proxemics (Terblanche 1996/1997:33) - and thus becomes an expression of intimacy and love, or hostility and anger. Collins (1977:67) confirms in this regard that "... the surest and most obvious way of decreasing social distance and making one's presence known is through touch, also called the matrix of many nursing activities".

Touch during the psychotherapeutic interview

With reference to touch in the psychiatric and counselling context between therapist and patient, a wide variety of differing opinions can be found. Some schools of thought condemn any form of touch during therapy in order to prevent sexual feelings or even displays of anger, and some researchers even classify it as unfit, criminal ruthlessness on the part of the therapist (Autton 1989:93).

More recent views would like to prove that a single act of touching can certainly communicate an atmosphere and climate of acceptance and involvement, although the body parts being touched should be strictly non-erogenous, such as hands, arms or shoulders. However, the receptivity to touch depends on both the specific characteristics of the touch gesture (for example form, duration and location) as well as on the message conveyed by the particular type of touch.

Other intellectual schools persist by saying that touch can be valuable during therapy, but that it can interfere with transference, foster dependency, and in effect be detrimental for the relationship between therapist and patient. "Skin contact is potent stuff, precious, and also dangerous. It can speed up or stimulate therapy that is bogged down in trivial verbal details. But to use it casually without much talk and exploration, without conscious assessment of impact and relevance, is foolish", says Forer (in Autton 1989:89).

In *Totem and Taboo* by Freud (in Legget 1994:48), it is mentioned that touch is the first step in acquiring control over, or an attempt to make use of or rather abuse, a person or object. In the context of psychotherapy, the therapist should aim to combine a safe atmosphere, in which the patient can meet and explore his or her "own real self", with emphatic attention and feedback in order to create a climate for improved intimacy, trust and independent thinking on the side of the patient (or receiver). Should the therapist exploit this situation in order to satisfy personal needs different to that specified in the original agreement or contract between himself and the patient, it can only give rise to erosion of the patient's trust and self-esteem, and damage the complete purpose of therapy.

In the psychotherapeutic dimension, touch can thus communicate both positive and negative message content - positive when it aims to communicate warmth, nurturing and confirmation, and negative when it goes hand in hand with fear of defeat. Touch can therefore be applied constructively or destructively, with far-reaching consequences for the patient.

Touch as an aspect of healing and reassurance by the doctor to the patient

The sick person, with the possible contagiousness of disease, or as a result of injuries or pain and the mere feeling of being sick, are quite often physically isolated. A mother will not touch her children while sick for fear of transfer of the disease, or because she is physically separated from them while in hospital.

Consequently, ill patients experience a real physical distancing from their loved ones, together with an emotional and spiritual separation, often intensified by pain or discomfort. A loss of control of the situation and circumstances are also implicated in the case of illness. The absence of touch and implied acceptance and comfort will probably result in an increased need for touch.

Calnan is of the opinion that the traditional view of the doctor's role in the community, can be summarised as "to cure sometimes, to relieve often, to comfort always"(1983:122). The critical matter, however, is how this should be applied in reality, because 'to comfort' is seldom being taught in a medical school.

Reiser and Rosen (1984:154) indicate that the act of touch is essentially related to acceptance, a basic principle of medicine as a human experience. All people start life as physical organisms, and long before language and abstraction is developed, we experience the world by means of our senses and what we feel. This occurs primarily as a result of touch, when we begin to distinguish and identify messages of love, security and survival.

Human touch is therefore one of the first and most critical encounters in the process of baby and mother bonding. Current medical training models ignore such matters as trivial, and the aforementioned authors plead for a systems approach to healing and medicine. Within this context, touch will be a sign of growing rapport, empathy and a new consciousness of shared humanity.

Reassurance and involvement during the process of healing and curing are often communicated verbally and nonverbally, while the latter carries the implied message. Touch can obviously be applied in a very constructive way to communicate comfort and care, such as when the doctor holds the hand of an anxious patient or bereaved family member. Young children are particularly vulnerable to touch, and such an act can be applied with positive outcomes in the treatment of this group of young patients, who experience illness and pain as very traumatic. The code of touch can undoubtedly be applied as reinforcing or supporting forms of positive verbal messages of reassurance and love.

A study by Durr (in Autton 1989:48) shows a direct correlation between physical touch and proximity, and the therapeutical effect in critically ill and anxious patients. In this study all the respondents indicated that they experienced physical touch as messages of

physical support and enhanced understanding, as well as confirmation of the verbal message from the health care worker. Two patients, ages 17 and 60 years, described touch in this study as the only helping factor in a situation where they were panic-stricken.

Touch is often seen as more acceptable when displayed toward disabled people. When people do touch severely disabled people from a perspective of acceptance and love, a real human being is found in the distorted body or brain, and unity then becomes a simple fact. Because disabled people understand fewer verbal nuances, physical contact becomes an important medium and instrument to continued communication.

Although many infants prefer verbal messages directed to them, research by Thompson and Gilloti (in Ray 1993: 89-90) pointed to the fact that most communication occurring around neonatal babies in intensive care, were directed to other adults, and could be called "talkovers" rather than "talk-to's". Where babies are directly addressed, the messages are always supported by touch, and "talk-to's"are seldom encountered without touch.

Research has shown immediate, physiological responses on the side of babies in reaction to speech combined with touch. The babies' pulse quickened during similar encounters with caregivers. Numerous neonatal nurses are instinctively aware that babies should be touched in a therapeutical manner, such as rubbing the baby's back, head, arms and hands, caressing the buttocks, or to let the baby take hold of one of the adult's fingers.

When young children and babies become severely sick or hospitalised, their need for comfort and security are urgent, and they trust their caregivers to touch them in order for reassurance that they are still being loved and comforted. Mothers hug, kiss and caress the young child who operates instinctively, rather than communicating a message of verbal words which the child will certainly also understand. Wordless touch reminds a child of a mother's love and presence.

Studies with sick children have shown that the child's gender is decisive with regard to stress relief which goes hand in hand with touch. According to Westman and Moss (in Autton 1989:53), newborn baby girls are more sensitive to touch than newborn boys, whereas boys are being touched more frequently during the infant years.

RESEARCH METHODOLOGY

Certain categories were deducted from the literature overview in order to compile a guide for the purpose of developing an open-ended questionnaire with a sample of patients. The questionnaire consisted of 25 questions mostly exploring touch in the doctor-patient-relationship.

Sampling

The questionnaire was distributed to 21 patients being hospitalised in two different hospitals in Bloemfontein (*Hydromed and Cairn Hall*). Of the original sample, 20 of the questionnaires could be used for interpretation. Personal data required of the patients were: age, gender, home language, city or country residence, and lastly the nature of disease for which the person was being hospitalised. No personal identity was required.

Method of data gathering and interpretation

The open-ended questionnaire was completed by the respondents themselves, although the researcher was available for assistance. The patients were able to complete the questionnaires themselves, except in two cases where the researcher facilitated the process and clarified comprehension by means of more probing questions.

Analysis of data

The raw data in the questionnaires were interpreted by means of both quantitative as well as qualitative content analysis methods. During interviewing, closed questions with pre-formulated responses would qualify as quantitative research, whereas open-ended questions where any response is noted, can be described as a form of qualitative analysis.

Fiske (1982:119) wrote that content analysis was designed and developed to produce objective, measurable and certifiable reflections of the manifest content of messages (as deduced from the open-ended questions) in order to get indications of denotative meaning. In this study, the responses for every open-ended question were noted and interpreted accordingly. Because of the number of respondents (N = 20), it was possible to infer percentages for responses.

EXPOSITION AND DISCUSSION OF FINDINGS

(N = 20 = 100%)

Ages of respondents varied from 21 to 48, mostly living in the city.

Diseases covered a wide spectrum, from surgery to depression. Since women were more willing to participate in the research, the majority of questionnaires (15) were completed by women.

Although it was obvious that the majority of the respondents are not clear on the *exact definition of communication,* they were aware of the fact that it referred to successful interaction between both a communicator and receiver. Only two persons (10%) referred to the use of different codes, while five (25%) patients mentioned that sharing of meaning was implied in communication. When tested on examples of communication from their own lives, nine patients (45%) indicated informal social conversation, while only four patients (20%) made a distinction between verbal and nonverbal communication. It seemed as if the majority of respondents preferred the verbal code of communication, and specifically in the two-person (dyadic) context.

With regard to *what people think of when they hear the word "touch",* a variety of responses were received. Six patients (30%) indicated that they thought of the physical act of using your hands and touching someone or something, while only one respondent responded that he/she also thinks of sex. One person mentioned "contact", one referred to "greeting", and one indicated "hugging tightly"as an interpretation of the word. For one person it meant reaching out and empathy, while another said that it refers to a high level of communication. One patient interpreted the word as communicating a message of warmth and friendliness.

Half of the respondents (50%) indicated that *they viewed touch by other people* as essentially important and positive, while the other half also expressed a need for touch but subject to the right context, and proper content. Only two patients (10%) saw touching as neutral or blatant. All patients (100%) indicated that they did not interpret the use or implications of the word touch as being sexual, and one respondent (5%) thought of both sexual and non-sexual implications.

With regard to the aspect of *touch being applied non-sexually by the health care worker* in a medical context, 90% of respondents replied that it was not only possible, but necessary, while two patients (10%) said that touch could not occur platonically or professionally in the medical context. Meanings ascribed to the word "touch"were diverse: sympathy, joy, understanding, love, greeting, attraction, empathy, aggression, interest, support, friendship, sex and uncertainty, hate, compassion, comfort, caring, acceptance and encouragement. Only two people (10%) thought of both positive and negative connotations.

When asked to *recall whether they have been touched* by either the doctor or nurses as a form of communication during their hospitalisation, only 50% of the sample responded by stating that they noted being touched in a positive way by personnel. Thirty per cent indicated that they were not touched at all in a therapeutic manner by personnel, and that they had an actual need for positive emotional touching during their hospital stay. Those 10 patients (50%) responding that they were indeed touched, interpreted the act as an indication of sincerity, warmth, support, love, care, understanding and encouragement.

When questioned about their doctor touching them, respondents gave the following as *interpretations*: support, understanding, professionalism, sympathy and empathy, caring, physical examination, friendship, kindness, duty and greeting, which added up to all 20 patients feeling positive about the doctor touching them, and so sending a constructive message.

In response to the question about the implications and *effect of touch from their doctor,* seventy per cent (N=14) patients indicated that it helped them in the sense that they felt they were really cared for, that they were supported and comforted, that it indicated a relationship of trust and compassion, and that it relieved tension and anxiety. Only one respondent (5%) said that touch had no effect on his/her experiences and feelings, while 95% viewed touch as potentially positive, and that it could contribute in a very real sense to healing and recovery.

Stating their opinion on *whether people should touch each other more* in order to communicate more effectively, 13 patients (65%) expressed a longing for more touch during communication, while the remainder put conditions of honesty and respect as condition to the act of touching. Three people (15%) indicated that it could convey meaning better than verbal communication, and two patients (10%) referred to their personal space not to be invaded.

The majority of the patients (80%) responded positively when asked about their opinion on the *quality of their relationship with their physician,* while one patient (5%) said that doctors should be more honest, one that doctors thought that patients were stupid, and two (10%) that it was very average. Approximately the same distribution was found when tested on the relationship between nursing personnel and patients.

With reference to *which part of the body* patients would prefer to be touched by health professionals, the following were indicated: 50%

(10 respondents) preferred to be touched on the shoulder, 30% (6 patients) on the hand, while 20% (or four patients) preferred a platonic hug.

Seventeen people (85%) responded that they would feel better and more positive (also more calm) about their *hospital stay* if people would touch them to demonstrate support, encouragement and understanding, while three (15%) patients were uncertain or said that it would have no positive effect.

Answers differed when asked if they were of the opinion that *people considered the act of touch as meaningful during communication.* Seven patients (35%) said yes, four (or 20%) said no, two (10%) stated certain conditions for a positive effect, while the rest (35%) were uncertain. Ninety per cent of the respondents thought that touch was an instinctive, non-conscious act, while 10% (or two patients) were of the opinion that it was contrived.

Nine patients (45%) implicated the perception that *doctors do think of the possibility to touch a patient* in order to convey a positive message, while two (10%) denied that doctors ever thought about this option. Four patients (20%) said that doctors sometimes seemed to consider touch as a means of communication, while one patient (5%) indicated uncertainty. One patient (5%) said explicitly that doctors never thought about emotional problems or needs in their patients. Twelve respondents (60%) considered touch as not being only present in intimate and loving relationships, while four (20%) of the interviewees said that it was mostly a product of intimate relationships. A further four people were uncertain on this issue.

SUMMARY AND RECOMMENDATIONS

It appears that the majority of the patients, albeit women, feel positive about the act of touching in the sense that this nonverbal code of communication carries positive and constructive meaning, which assist people to cope better with their diseases as well as making their hospitalisation more bearable. It was noticeable that positive connotations were made with regard to the word "touch". Few respondents saw touch as having sexual, deliberate implications, and definitely longed to be touched more by other people, especially when sick, anxious, discouraged and fearful.

Combined with results of studies in the literature, it was clear that doctors as well as professional health care workers should touch people more while they were sick or hospitalised. However, certain

conditions were stated, such as genuine and spontaneous feelings. The body part must be neutral in most cases.

It can be suggested that health care workers should pay more attention to the needs and feelings of their patients, and that the nonverbal codes of communication, particularly that of touch, have a lot of potential to improve the relationship between patient and health professional.

The act of touch infers a positive message, which can definitely contribute to healing with therapeutic effects on the patient. Thayer's findings (1986:24) are indeed confirmed when he says that touch is the gatekeeper of the inner person, being the final connection between people, particularly when words are not enough. An incidental observation, which could be explored further, indicated better cognitive skills, more pronounced needs and a better emotional understanding of touch and communication under patients being hospitalised for depression and/or psychological/emotional treatment.

It is always important to keep the broader context of communication in mind. Such a distinction could be illustrated by the difference between history-taking and interviewing. Most students are actually educated in the process of history-taking while in medical school, where they are primarily alerted to interpret the patient's verbal responses, but in actual fact are thus conditioned to ignore or at least underplay the patient's as well as their own nonverbal behaviour. Verbal and nonverbal communication should be seen as inseparable at all times. These aspects could however supply crucially important clues, if not information, about covert and subconscious matters and problems. The earlier these skills could be acquired by the physician, the sooner the quality of the doctor-patient relationship could be addressed and improved, particularly within the context of the following quotation:

> Pause and consider for a moment the real significance of touch, the craving that human beings have to be embraced when they have suf-fering and in pain. Yet touch appears to be on the decline in medicine, too often denigrated, ignored, and unappreciated. Some, in the name of some ill-conceived notion of therapeutic purity, have actually advo-cated that it be abandoned. Touch, intimacy, closeness, a sense of belonging - many fear that their disappearance from medicine deeply hurt patients. Sadly, this is true, but we worry about something beyond this. Alienation is also taking its toll on the doctor. (Reiser & Rosen 1984:152).

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