

Hands as Diagnostic Tools in Medicine. Should Physicians Touch Their Patients?

Roberto A. Franken¹ e Marcelo Franken^{2,3}

Faculdade de Ciências Médicas da Santa Casa de São Paulo¹; Unidade Clínica de Coronariopatia Aguda do InCor – FMUSP²; Unidade Coronariana Hospital Israelita Albert Einstein³, São Paulo, SP – Brazil

The Creation of Adam, a section of Michelangelo's fresco Sistine Chapel ceiling, illustrates the Biblical creation in which God gives life to Adam, the first man. The image of the near-touching hands of God and Adam has become one of the most iconic images of touching as a way of giving life. Hands have always had an important significance in the fine arts, poetry, literature, and movies, expressing feelings, such as solidarity, charity, caress, companionship, love, affection, cure, protection, and commitment.

Medical activity in its evolution to the clinical diagnosis of diseases can be divided into three parts: communication¹; technique (knowledge and skills); and ritual.

According to Jewish tradition, the healing process of a patient involves the physician's eyes, mouth, and hands, which currently represent the processes of communication, manual skill, and everything else such senses can perceive from patients and transmit to them.

The concept of disease has changed with Thomas Sydenham, when he observed that symptoms and signs were not diseases as Hippocrates had assumed, but manifestations of the natural history of each illness, and that equal symptoms could be present in different diseases. In 1731, Leopold Auenbrugger, an Austrian physician, noted that his father, owner of a lodging-house, assessed the wine contents of a barrel by tapping the barrel and noting differences in sound. Leopold Auenbrugger then decided to repeat the procedure by tapping his patients' chests. This was the first time clinical signs were used for diagnosing chest diseases. In the evolution of investigative procedures, Laennec replaced direct chest auscultation with the monoaural stethoscope, thereby allowing the physician to make a diagnosis without having to touch the patient's body. Those two procedures might have been the first objective landmarks for the clinical diagnosis of diseases.

Alongside a patient's clinical history, a physical exam allows a diagnosis to be established in up to 85% of the cases.

In the past, patients' care consisted of rituals performed by witches, shamans, wizards, priests, and kings. Hands were

the major tools used in such rituals, which were not aimed at diagnosing, but rather drew on the performer's personal power to relieve symptoms and, often, cure the patient².

From the 17th century onward, with Descartes, medicine began to focus on diagnosis and, thus, on the adequate and specific treatment of each disease. The ritual, however, persisted in the collective unconscious of medical activity, currently represented by the clinical exam, which the patient both expects and desires. There would be no other reason to justify the patients' frequent claim that "the doctor has not even laid a hand on me", nor the common statement that patients being cared for by a certain physician are in good hands.

The act of a physician touching a patient with his hands is part of the medical consultation from both the technical and symbolic viewpoint. One cannot accept a consultation with a urologist without the digital rectal exam, or a gynecological consultation without clinical breast examination. That is the patient's fair expectation, even if palpation is known to have low sensitivity and specificity in the early diagnosis of breast cancer, and mammography and/or breast ultrasound are immediately requested for women, and pelvic ultrasound and PSA measurement for men.

Nowadays the physician touching a patient with his hands is seen as an accomplices' agreement between the physician and the patient, a commitment that everything will be done in the search for the diagnosis, excellence of treatment, and solidarity. This would be equivalent to saying "we are in this together".

Medical education has neglected the patient's clinical exam, as well as the data derived from it along with the clinical history. After this first approach, diagnostic hypotheses are raised, and, based on such hypotheses and on the sensitivity and specificity of the data, subsidiary exams more adequate for establishing the diagnosis are requested.

The bedside evaluation and classic education have been replaced with the analysis of data on computer screens. Imaging exams, laboratory tests, vital signs, and prescriptions without the need to talk to the patient or even to look at him are right at hand. The patient has become an icon on the screen, no longer a person/patient/client, but an "ipatient/iclient/iperson"³. The discussion, originally centered at the bedridden patient, is now centered at the computer monitor. If we ask a patient if he is happy with this technological advance, the answer will certainly be "No". The patient prefers the communication and ritualization by use of the hands, and, only then, after accomplishing that phase, the use of technology. A successful professional performance depends on technical knowledge, skills, ability

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Mailing Address: Roberto A. Franken •

Rua Doutor Franco da Rocha, 163 / 52, Perdizes, Postal Code 05015-040, São Paulo, SP – Brazil

E-mail: frankenr@terra.com.br, franken@cardiol.com.br

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to communicate, and acting. The medical act is recognized in the physician's work as an implicit form of acting or dramatization, not as a metaphor, but as a model, according to Pine and Gilmore⁴. A salesman acts, a waiter acts, a barber and hairstylist act, a stewardess acts, why would it be different with a physician? The clinical exam and the use of the hands are the physician's form of acting, and the ritual is completed with the provision of valuable information for establishing the diagnosis. The Walt Disney Company recognizes that fact by considering, at their parks, each employee as a "cast member". Hospitals have understood that logic by making their facilities less austere, friendlier, from the reception to the patients' rooms. The environment has become friendlier, so why not do the same with the physician's practice?

In 1994, when Hillel Finestone and David Conter, physicians at the University of Western Ontario, published in the *Lancet* an article⁵ discussing medical practice as having a component of theatrical acting, they were criticized. Those authors reported that, if physicians do not have the necessary skills to satisfy the emotional needs of patients, their work is not complete. Those authors believe that the training of students should include training in acting, focused on meeting those emotional needs. According to them, medical acting is not a simulation, but an emotional exchange, directed, produced

and developed by the physician. The patient is the spectator, an adjuvant to that process, the one who writes the script to be acted out by the physician.

Currently Medicine provides diagnostic methods that use subcutaneous implantation of devices and proposes individualized treatments by use of Genetics^{6,7}. It cannot, however, ignore several medical acts, which comprise the ritual patients expect, the communication for clinical history taking, the use of hands for touching during physical examination, and, eventually, technology, so that the most precious diagnosis and subsequent treatment can be established.

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