Personal Narrative

Treasured touch - a perspective into human touch in medicine

Harsh Sharma, MBBS

Medical Graduate, Kasturba Medical College, Manipal; ORCID: https://orcid.org/0009-0004-1569-0566

Corresponding Author:
Dr Harsh Sharma,
Kasturba Medical College,
Manipal, Karnataka - 576104, India.
Email: harshsr019 at gmail dot com

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As I navigated past crowded corridors full of patients to the surgery wards, it occurred to me it was my turn to present the patient during clinical teaching today. For 3rd year medical students, surgery is quite literally Greek and Latin, and our clueless faces are an unforgettable sight. But nonetheless, we persevere till it eventually makes sense.

Making the patient feel comfortable and getting them to trust you is an arduous task for medical students, and a language barrier only adds to the list of hurdles. Our patient was a man in his early 40s who presented with a painfully swollen, blackened thumb. He was a farmer, and all he was worried about was how quickly he could get back to work. His was a case of dry gangrene due to subclavian artery occlusion - a nasty clot in the artery that led to the arm. Contrary to the usual encounter, this patient was rather friendly and was willing to let us examine him (patients seldom realize that the figures huddled in the ironed white coats are medical students, and not really doctors yet).

My batchmates nudged me forwards and assured me they'd dig for his medical history while I figured out the physical exam. One of my friends handed me a pair of latex gloves, and I put them on out of habit, one naturally acquired after spending an entire year in the cadaver dissection lab. With my gloves pulled on, I began to test if my medical student brain could figure out what was going wrong here. My hands began to sweat, and I flinched every time the patient winced in pain when I palpated his thumb.

I was frantically going through my notes, revising my examination findings, when the professor quietly walked in. He immediately noticed the gloves on my hands and asked why I had them on. To my surprise I didn't have an answer. Why did I have gloves on? Surely the patient did not have a communicable disease? Nor was I examining anything that would bring me in contact with body fluids. Was it to protect the patient? From what? Had I failed to recognize the difference between a cadaver in the dissection hall and a farmer with a beating heart? Did I see him merely as a physical encasement of the principles of physiology and pathology? I went blank.

I got reprimanded - and rightly so - the first of many in this long journey. The patient looked at me worriedly, oblivious to the words yelled my way in a language foreign to him. A heavy shroud of guilt cloaked me. What sense did it make to use gloves to touch the hands of someone who was no less human than myself? To make him feel alienated, to further confirm to him that

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something was evidently wrong. That he didn't even deserve the touch of a fellow human.

I learned that day, and many times since, that when one holds the hand of a patient, what seems like a routine gesture actually carries profound human connection. It eases an anxious mind, and makes the patient feel connected to the doctor not just as a caregiver, but also as a fellow human being. It carries reassurance, and also alleviates some of the pain.

The professor asked us to demonstrate the examination in front of him this time. Call it serendipity, or a well-rehearsed attempt, but I managed to get it right and this was enough to win back my professor's approval. He patted me on the back, and said I'd done a good job. The patient grinned at me with a smile too big for his face. I left the ward that day having learned not only about Virchow's triad, but also about the value of mere human touch; about the disguised power and respect that lies in the contact of epidermis with epidermis.

In some situations, examinations with gloved hands are necessary to uphold the principles of universal precautions. In other situations, not touching the patient, or examining the patient with gloved hands might be perceived as discriminatory, for example a patient with HIV would feel quite alienated and stigmatized.

In our current packed medical curriculum, there is very little time given to medical students to develop their affective skills. It is, however, important to have appropriate bedside manners to communicate with and interact with patients. We are taught how to hold a patient's hand, but it is for the purpose of clinical examination: Allen's test for the patency of the radial and ulnar arteries, Corrigan's sign to look for collapsing pulses in aortic regurgitation. However, no defined method to hold a patient's hand as a way to communicate can be found in our usual textbooks. In any case, can we really expect someone to learn how to empathize through a didactic lecture? We learn it - or don't - depending on our own experiences and practice. We can learn these skills by watching our professors and colleagues - role models - and then we hone them through practice. It's something that has to be caught on to, if not actively taught, and then ingrained into our instincts. The technique might differ based on gender and culture, yet it is a skill that should become intrinsic to us all. It is what turns the science of medicine into the art of medicine.

It's not uncommon to find physicians in such a tremendous hurry that they see the disease and not the farmer, labourer, or musician sitting in front of them. The patient doesn't want only a prescription or a procedure. Sometimes, they need an ear to listen to their plight, a confidante to share their woes, or physical touch - their hand being held to reassure them that things will be alright one way or another.

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