REFLECTION

Losing Touch in the Era of Superbugs?

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ABSTRACT

Nosocomial infections are increasingly multidrug resistant and at times more virulent. As such, they pose real threats to patients and clinicians. In this essay the author discusses his own methacillin-resistant staphylococcus infection and how it has affected his work in the hospital. In so doing, he reflects on the value of touch in the doctor-patient relationship. In particular, he discusses how gloves serve as a barrier to infection but also create a small distance between the doctors and their patients. The implications of contact precautions must be considered as we reflect on balancing patient-centered care with infection control.

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The plastic gloves I put on as I enter the patient's room are 2 sizes too small. They pull at the hairs on the back of my hand. Locating them, putting them on, disposing of them, all add to the sense of busyness that pervades my days as a hospitalist. Then, of course, there is the physical separation that the gloves create—something that gives me pause.

The room I enter is that of Mr Jones, a 54-year-old man with poorly controlled diabetes and a 1-cm ulcer on his left great toe. I explain, in what has become an extended part of my introduction of myself, that I wear gloves when I examine all patients to curb the spread of germs. As is typical, I hear no hint of disappointment from him, but for me, there inevitably is a slight sense of loss as I proceed with my examination.

Mr Jones leads a life that appears to have little intimacy. He lives alone in a notoriously rundown residential hotel where he keeps to himself to avoid the violence that plagues his neighborhood. Upon admission, he detailed to me with frustration the difficulties he has had getting care. Last week when he called a county clinic about his blood glucose levels of 350 mg/dL, he was told to follow-up in 4 weeks. Getting Mr Jones's glucose levels down and treating his foot infection won't be enormously difficult, but in the long run what he needs to improve his health is to feel invested in his relationship with the health care system. Faith in one doctor might provide him with the perseverance he needs to connect with another doctor in the haphazard world of safety-net health care. Any distancing could jeopardize the building of trust essential in a good doctor-patient relationship. I am afraid he might experience my use of gloves as a desire to keep an emotional in addition to a physical distance.

Leaving Mr Jones' room, I hear cries in Cantonese from another patient of mine, Ms Chua. She is 89 years old with advanced dementia, and she had been sent from the nursing home because of increasing agitation and a fever. Twenty-four hours into her admission her fever has abated, but she has remained agitated. I enter the room, speak in soothing tones, and gently stroke her forehead. The smooth glide of skin on skin is missing. My hands, sweaty in the vinyl gloves, move less fluidly than they otherwise would. There is a loss of what could have been a brief soothing moment for us both. Even in her delirium, I imagine she can tell this is an institutional comforting because of the feel and smell of plastic.

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My sense of loss commingles with ongoing ruminations about the consequences of not having started to wear gloves sooner. I have always thought I was a good hand-washer, but if I had been wearing gloves routinely last year, perhaps my daughter and I would not have been hospitalized with methicillin-resistant *Staphylococcus aureus* (MRSA).

Last year Josephine, my 10-year-old daughter, scraped her knee on the playground; for 2 weeks it was sore, and then suddenly it was red and warm. I started her on trimethoprim-sulfamethoxazole; even so, she had a temperature of 102 degrees the next day, so we brought her to the hospital, where she stayed for 3 days getting antibiotics.

A month after that, I developed pain in my arm without any redness or swelling. In an effort not to doctor myself, I saw an orthopedist who thought it was a biceps tear and put me in a splint. Two days later, I returned from work in worse pain and exhausted. After I collapsed on the couch, Josephine took off my splint and made the diagnosis. "Daddy" she said, "you have the same infection I had. You need to go to the hospital."

I had developed a deep tissue infection without a clear port of entry and, as were my daughter's, my wound cultures were positive for MRSA. During my hospitalization I was happy to be handled with gloved hands. I needed a couple of surgeries to ensure the wound was clean then went home on intravenous vancomycin

My wife, an epidemiologist, asked about treating our other young children and sterilizing the environment after our daughter's hospitalization. I explained that, despite my urge to treat the whole family with mupirocin and topical antibacterial soap, I was following the recommendations of the pediatric infectious disease guy I had cornered during my daughter's hospital stay. "MRSA is pandemic." he said, "There is no reason to treat it differently than other skin infections."

When I was hospitalized, my wife, at home with our 3 young children, was immediately on the telephone with her physician colleagues and getting informal consultations from national authorities on staphylococcus. She also got a good dose of MRSA horror stories–including tales of loss of limbs, life, and recurrent infections in colonized households. When I got home, she and the kids were on a 2-drug regimen and getting daily chlorhexidine baths. Never was a house so clean, but with an invisible threat, it remained hard to feel entirely safe.

My return to work after my illness was more difficult than I like to admit. I reflected on my training in family medicine at San Francisco General Hospital. I learned to focus on the whole patient rather than their specific ailments. Sometimes 50% of patients in my care of had human immunodeficiency virus (HIV). Advanced HIV brought with it other infectious concerns, such as tuberculosis, but I went about my work fearlessly out of professional duty and solidarity with my patients. I remember feeling self-righteous at what I believed were overly vigilant and stigmatizing precautions being taken by other health professionals. I hoped these memories would bolster my determination to "lay on the hands" again. But the hospital wards that had been so familiar now seemed like uncontrollable pools of pathogens the rest of the staff managed to blithely ignore. In every patient I saw threats to my family and myself. In addition to wearing gloves and now a white coat as well, I washed my hands, stethoscope, pagers, and pens obsessively. This behavior has improved with time, but I still feel that I am putting my family at risk every day I go to work. Given the trajectory of drug resistance, it is hard to imagine these thoughts will ever entirely go away—nor do I honestly think they should.

I understand objectively that I do not need to wear gloves with all my patients, but for a great number of patients, all clinicians must take considerable precautions to prevent the spread of infection. Guidelines support the use of alcohol-based foam products rather than gloves except when multidrug-resistant pathogens are confirmed, but given the increasing rates and virulence of these organisms, I am not convinced such measures will continue to be enough to protect our patients.[1,2] I know, however, another important reason I now wear gloves is out of fear for my family and me.

Yet I see touch as a communication tool. For me, touch is particularly important when trying to bridge large socioeconomic and cultural gaps. A hand on the shoulder or the knee or a thoughtful physical examination, I believe, can make a patient understand at a deep nonverbal level you are there for them. I work hard to demonstrate concern for my patients with tone of voice, facial expressions, and body language, yet I feel I am losing some connectedness without skin-to-skin contact.

At the end of the day I go back to see Mr Jones to relay to him some good news. His bone scan suggests he does not have osteomyelitis. With the news of his scan, Mr Jones smiles for the first time in the 3 days I've been seeing him. "I guess I'll be getting out of here in a couple of days then. You'll follow me in your office, won't ya doc?"

I put a gloved hand on his shoulder and say "I don't see patients outside of the hospital, but I'll send you to see my buddy at the downtown clinic; she'll do you right."

"That's what I need, doc. Someone I can count on."

"You're a good man, Mr Jones," I say as I prepare to leave the room. "It's going to take hard work to get yourself healthy again, but I know you can do it."

As I toss my gloves in the trash and head out of the room, I realize that the people most in need of touch—those who have the greatest need to connect with a fellow human being, those I did not hesitate to touch without gloves in the past—have now become those I am most hesitant to touch without them. I am working up to not wearing gloves all the time. I hope that as I do become more relaxed, I won't stop paying attention to nonverbal communication or the psychological consequences of illness, and my patients don't end up feeling dehumanized by their hospitalization. We must not "lose touch" with what it is to provide patient-centered care as we navigate the increasingly complicated world of medicine in the 21st century.

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