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PHILOSOPHICAL EXPLORATION

Touching the Spirit: Re-enchanting the Person in the Body

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Abstract In this essay, we argue that touch constitutes a sacred connection between the patient and practitioner. When touch is avoided or overlooked, the enigmatic inner workings of the body are ignored as those aspects of the body that can be quantified and ultimately controlled are emphasized. In utilizing touch as a fundamental way of opening up space for the sacred, the practitioner affirms the humanity for both the patient and herself. Only by returning to the senses can practitioners resist the dehumanizing effects of machinery and re-enchant the health-care profession in caring for persons they have sworn to serve.

Keywords Touch · Healing · Care

At a 2016 TedX talk, Nurse Susan Cooley, Ph.D., describes her experience as a patient. A nurse for almost 40 years, Dr. Cooley speaks with authority and the wisdom of someone who has cared for thousands of individuals. Like other health-care providers who have found themselves in the bed rather than at the bedside, Dr. Cooley shares insights that are unique to those who have moved between both positions.

Dr. Cooley was indeed extremely ill, with diagnoses of dehydration, pneumonia, and sepsis. Although indicating that she felt herself "slipping away," Dr. Cooley still had the

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presence of mind to notice the attached monitors. In the TedX talk, she articulately describes her sensory experience of being a patient. She recounts the sights of the numbers flashing behind her head, the sounds of the "beep beep beep" of the machines and the "constant din of noise"…"with an occasional shrill alarm that goes off to tell the nurse that some number is out of range." Wryly chuckling to herself, she says that she can almost even smell the hospital (Cooley 2016).

Cooley (2016) also saw and experienced another phenomenon: After being hooked to the machines, the eyes of the nurses rested on the monitors and their hands stayed busy typing numbers into the computer. The nurses seemed to trust the numbers more than their examination of the patient. "Once the machines took over, nobody so much as looked me in the eye. Nobody palpated my pulse. Nobody listened to my heart; nobody listened to my lungs. Nobody *touched* me (emphasis hers). The stethoscopes just hung lifeless around their necks."

The team was competent medically, but Dr. Cooley laments that she never felt *cared for*. Dr. Cooley goes on to name several specific actions that would have made her less objectified. Someone could have put a rag to her head or offered to help her walk to the bathroom. Being treated like a customer, she argues, is unhelpful. Dr. Cooley wanted to feel kind, personal attention. She uses the words "abandoned" and "neglected" to describe her sense of self (Cooley 2016). This observation comes from someone who knows well the requirement of care placed on health-care workers. She felt fear as she lay in bed, helpless and at the mercy of these people who would not even place their hands on her sick body.

Sadly, Dr. Cooley's encounter is not unique. Stanford University Medical Professor Verghese (2009) notes, "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." Verghese recognizes that modern imaging gives "incredible pictures of the body's innards," creating the misconception that there is no other way to diagnose issues. However, Verghese does not want to abandon the physical encounter, calling physical examination "a sacred privilege." Even when a person is nearing the end of his or her life, there is value in the encounter, despite one's inability to cure:

> 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 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* (Verghese 2009).

Touch is not a random encounter between caregiver and person: Information may be obtained that can be pertinent to medical decision making. At the same time, the essence of caring is conveyed through the performative aspect of touching the sick body. Kelly et al. (2014) characterize touch as "an affective dimension of care, the power of which extends beyond words".

In the sterile world of the hospital, touch can be emotionally risky. Touching applies a form of closeness necessitating interaction between two people. As a fellow human, the clinician also requires care and in the tactile encounter between clinician and patient, the sick body returns the touch. As humans sense each other, the sick person might also be able to perceive the healer's own vulnerability, as well as their strength and caring.

With the intervention of scientific discovery, the enchantment of the body is no longer present: machines can now "see" the inner workings of the body, and touch has been relegated to a lesser skill. Dr. Cooley speaks of the absence of touch as her body was ravaged by infection, with medical personnel focusing on the monitors that flashed performance indicators. She laments that her practitioners looked at the machines more than her face and listened to the beeps of the machines more than her human cries. Yes, these practitioners were doing their basic jobs, but as a sick person in need of care, Dr. Cooley wanted more. She (2016) condemns the gap between the machines that signify the medical complex and the humans who are connected to them. In this strange space where machine and body meet, touch gets relegated as secondary to the technological capacities of diagnostic equipment. With human engagement taking a backseat to the technical, it is no wonder that ordinary people are disenchanted with modern American medicine. Dr. Cooley's sad but prescient observations expose forces that continually threaten the practice of medicine today. Rousseau and Blackburn (2008) note that "From the time of Hippocrates, touch has not only allowed the physician to discern, detect, and diagnose, but to also display an emotional posture of empathy and caring." In discounting touch, medicine's praxis confers more emphasis on images and numbers instead of the emotive encounter.

In this essay, we argue that when the practitioner ignores touch, a sacred connection between the patient and practitioner is lost. As the progress of scientific discovery moves ever forward, the body's mysteries become reconfigured as problems to be solved. Clinicians emphasize those aspects of the body that can be quantified and ultimately controlled. Laboratory tests can check blood pressure, sugars, and kidney functions. Psychological tests can even determine mental state, depression, or loneliness. Neither existential angst nor human suffering can be measured. No biomarker can fully capture the sense of well-being that arises from a morally rich encounter between two persons. These elements of medicine may measure the workings of the body, but raise the risk that an encounter pregnant with meaning becomes one that is merely a mechanical act between a technician and a dehumanized body.

Perhaps touch might be unimportant if persons were only body machines without considering their interrelatedness to others. Made up of flesh but not reducible to it alone, the whole person should be the practitioner's focus, whether as patient or as family surrogate for those who no longer speak for themselves. Skin separates two humans from one another, but each can apprehend the other's humanity through sensual interaction, letting both humans know that something ineffable is also present within the physical body—a thing that could be called the soul. We argue that by addressing the whole person and engaging both body and soul as an integrated organism, medicine could be reinfused with a sense of wonder and awe. Medicine, indeed, could be re-enchanted in such a way that the mysteries of the soul are attended to even as the mysteries of the body are controlled.

Indeed, recognizing the sacred, immeasurable elements of the human is the central foundation to infusing wonder and awe back into the medical encounter. Returning to the ancient source of healing—the use of the senses—could be the vehicle for imparting enchantment back to medicine.

In exploring the thesis that touch is integral to re-enchanting medicine, we consider the evidence of the fundamental value of touch and its evolution away from a place of prominence in contemporary medicine, appraising the barriers and benefits of touch. Finally, we offer an approach to re-imagining the person that fully embraces the value of touch in medicine, affording it equal status with the technological tools of care.

Touch as Primary and Sacred to the Clinical Encounter

Tangible examples of the importance of touch are most notable at the beginning and end of life. At the beginning of life, the behaviors of infants provide an exemplar of the primacy of touch as an element of humanity. Research shows that infants lacking human contact do not thrive. Recognizing the need for touch has extended to neonates born ahead of term that require the protective environment of an incubator. Special practices have been developed to promote skin-to-skin touching between these fragile newborns and their parents. Over time, experience demonstrates that the technologically supportive environment of the incubator needs to be augmented with human touch. Skin-on-skin care has been shown to have a calming effect on infants while promoting better physiological symptoms such as temperature, heart rate, and oxygenation (Baker-Rush 2016). For the premature infant's survival, human contact matters just as much as the numbers. Additional studies show the value of extended massaging touch as a means for promoting well-being, resulting in decreased deep sleep, agitation, and heart rate for premature infants, along with reduced stress hormones (Asadollahi et al. 2016). The absence of touch is harmful to the newborn, and its presence adds support to the infant's physiological ability to thrive.

The propensity for touching emerges as a factor present before birth. Recent imaging studies with in utero twins demonstrate that movements between the fetuses begin as early as 14 weeks (Castiello et al. 2010). Castiello raises the specter that touch is a physiological experience without conscious effort—humans are drawn to physical interaction, and its absence will likely have ill effects on the human organism. Fetuses sharing the womb demonstrate a propensity to seek touch innately, without external stimuli. Once born, the necessity for touch perpetuates, with the infant requiring consistent support in order to thrive and grow into full personhood.

Life proceeds with many opportunities and needs for touching, with its importance especially prevalent as the body faces illness, ages, or comes to the end of its mortal existence. Numerous researchers have identified the benefits of touch for providing comfort, reducing anxiety, and increasing closeness, particularly for the elderly. One Swedish study of workers dealing with aging residents with a variety of medical conditions including dementia provided daily touch, finding that both the providers and receivers of care benefited. While calming the senior residents, providers were empowered to relieve suffering without "having to ask superiors for medication and advice" (Edvardsson et al. 2003). For these providers, the simplest treatment was the demonstration of presence and caring provided by human touch. Moreover, the study participants observed "experiences

of increased calmness and well-being within themselves" (Edvardsson et al. 2003). The interrelatedness of humans is exhibited in the fundamental sense of touch.

In reaching out to others, caregivers discover their own benefits that help to conduct work that might be discouraging at times. Finding meaning in difficult circumstances can stave off feelings of depression and helplessness that are common among care providers. Evidence supports the innate need for touch, even when one's total cognition is compromised or other senses have been affected. There is an apparent level of interaction that is not measurable. Touching is not a matter of medical machinery, but simply an interaction between two humans that is beneficial to both parties.

For someone who has lost verbal abilities through advanced dementia, touch may become the sole means of communication. Though they experience a loss of semantic memory and verbal capacities, the person with dementia will still make gestures that reflect the need to communicate. Once the ability to communicate using language is lost, body language reveals what the person may be thinking or trying to express. Through touch, feelings can be conveyed in a manner that overcomes the absence of words.

A brief story illustrates how one person with dementia used touch to communicate. A friend shared his dementia-afflicted mother's propensity to touch men at social gatherings in ways that she would never have dared when younger and words were more fluent. We laughed about the story, but the person's behaviors make sense. The mother's understanding of social boundaries was impaired, and what remained was a need to be attended to with a caring response. Through her actions, she communicated her desire for touch. At one time or another, everyone needs to feel cared for, and when one does not know what to say or how to express that need verbally, actions speak louder than words.

A study of touch in three Australian residential senior care facilities lends more support to the importance of tactile connection for persons with dementia. In one case, life-like dolls were given to residents, who caressed them, providing evidence of the innate sense of touch remaining even when words are gone (Nicholls et al. 2013). In another instance, a resident grabbed the hand of a massaging caregiver, providing a moment of concern about what situation might follow, but initial fears were quickly assuaged when the resident simply pulled the caregiver's hand to her heart (Nicholls et al. 2013). The caregiver clearly touched some hidden element in the person's being. Again, words were missing, but the emotion was present and communicated effectively.

Scholars acknowledge the complexity of touch as a phenomenon, with most citing the physical, emotional, and psychosocial elements of touch. One group of Swedish researchers sought to go beyond the definitional roles and "explore patients' lived experiences of touch in a clinical context," interviewing a group of ten women representing an age range of 36–87 with a variety of chronic conditions (Ozolins et al. 2015). From these interviews, four constituents were identified: the relationship supported by touch; interplay between humans; beneficence of the act; and the required presence of caring in the act of touch (Ozolins et al. 2015).

- Touch provides an anchor, albeit with firm boundaries;
- In offering a forum for interplay, touch connotes caring between the individuals that are party to the act;
- Touch enables the recipient to understand as well as face their emotions; and
- The caregiver has a responsibility to be attentive in order to serve the recipient's needs.

With these constituents, the reciprocal nature of the act is acknowledged. Touch is performed in an environment of caring, not one of power or condescension.

Leder and Krucoff (2008) note that the healing powers of touch can only be realized when compassion is present. The focus of the act of touching cannot be realized when the target is not acknowledged as a full person, the "'Thou' with whom the practitioner can identify." The benefits of touch can only be apprehended when performed in an environment of mutual respect and reverence. However, the advantages are very real, with the recipient experiencing new realms of calm, and the caregivers empowered to offer concern and attention that transcends the transactional encounter that reflects the more dangerous boundaries of modern, American medicine. In short, the person is acknowledged as the focus, while the health-care provider encompasses all of the beneficence demanded by the role of caring.

With the apparent benefits of touch, what drivers have led us to the place that medicine must refocus on this very fundamental element of relationship? What actions have led medicine to a focus on the numeric and measurable qualities of the human being?

Discordance with the Sacred

The clinical encounter, while not strictly embracing the sacred, nevertheless has quasi-religious characteristics that, when ignored, contribute to the feelings of disconnection between the one who is sick and the one who is not. Both the person and the provider are diminished when the potentially sacred features of modern medicine are overlooked. By not recognizing the elements, the opportunity for a rich, moral encounter becomes simply a mechanical interaction that denies the emotional complexity of the human experience. What remains is not a sacred encounter between healer and supplicant, but instead a profane transaction between the powerful and the powerless.

Religious historian Mircea Eliade's (1987) understanding of the sacred and the profane figures prominently into the relationship between the practitioner and patient. Even if the modern person presumes her life to be completely secular, echoes of the ineffable and numinous still reverberate and remind the modern person that rationality cannot conquer and explain away all forms of human experiences. Awareness of the relationship between the sacred and the profane is essential to medicine as a truly healing, and not merely technical, profession.

The history of medicine is dappled with the advancements that have threatened the numinous aspects of the clinical encounter; each medical discovery supports the thesis that the body is an object that can be mastered. Categories emerge and the body becomes something generalized. The unruly body becomes fragmented and reduced into its controllable components, which are signified by the measurements that mark whether the body is *typical* (Swinton 2012). Something typical is without wonder; it is, by virtue of its normalcy, mundane and regular. The mysteries and complexities of personhood are overlooked.

From the first day of medical school, students find themselves at the juxtaposition between the sacred and the profane. They must learn the workings of the typical body before they can learn how to bring the numerical signifiers of the sick body back into normal range. The mysteries of the body are revealed to be physiological processes that have rational explanations—from the systemic to the molecular level. The numbers that signify these processes, rather than the patient's particular and personal narrative, tell the medical story.

In order to gain this specialized knowledge, students must violate the taboo protected by the skin. Propriety is dismissed as budding physicians are handed scalpels and given visual access to the body in the anatomy laboratory. The scalpel cuts beneath the skin and exposes the secret machinations of the body. Witnessing the organs under the skin can call up feelings of wonder, dread, fascination, and awe—elements of the sacred, to be sure. Ironically, the sense of touch provides an entrée to the body for medical students. By examining and feeling the body and its various parts, students learn how the parts should be formed and relate to each other.

In such moments, students can respond in ways that either honor or deny the magnitude of the encounter. They may cultivate a measured reverence in relation to their feelings. They may take solace in dark gallows humor. Others may dismiss, ignore, or suppress these complicated emotions. With time, the sacred components of the encounter with the mysterious body can become mechanical and routine; in these times, the profane dominates. Treadway (2007), a Boston physician and Harvard Medical School faculty member concerned with the desensitization by practitioners to suffering and death, describes the intrusion of banality into the encounter with the once living human body:

> Where did we learn this detachment? For most of us, the first lessons came very early in medical school, when we were confronted with the dissection of a human body—conveniently called a cadaver, as though that made it something different from a person who had died. How rapidly we moved from our first tentative slices through the chest wall to look at the heart and lungs and then into the abdomen, finding ourselves lost in the fascination of how our bodies are arranged and overwhelmed by all we had to learn. Soon, we were casually slicing the head in half with a saw to see how it looked from the middle, having paused only briefly when we first unwrapped the hand, which struck us as uniquely and somehow poignantly human.

Treadway uses the word "casual," which implies both comfort and superficiality. Feelings of awe are taken over by a more laid-back approach—the fundamental mystery is discounted. However, by identifying the hand as being "poignantly human," the sense of touch is lifted as a superior method for representing the body's capacities and capabilities.

Later in the educational process, cadavers are replaced with living, breathing humans. The secret knowledge revealed by the cadaver must now be contextualized in the intricate human organism, which is much more complex than the physiological body. Standardized patients teach students how to touch inspect, auscultate, percuss, and then palpate parts of the body and guide the students as they learn the elements of the clinical interview. With their eyes and hands, students learn to reveal the workings under the skin without disrupting its integrity. Their best tools in these moments are the senses as prospective physicians learn the fundamentals of the physical examination. These emerging professionals must learn to touch the body dispassionately, to gain a certain type of information. The body is ordered and reduced into its component systems to make the vast knowledge digestible. Further mysteries become generic aspects of human physiology or psychology, which can then be characterized further by the representative numbers that reflect normal or abnormal functioning.

In learning the medical interview, students gain access to further secret knowledge. They learn that by asking clinically direct questions, patients will reveal some of the most intimate, hidden aspects of their lives, from hygiene habits to drug consumption to sexual practices. Students break taboos again as they learn secrets that patients would tell no one else. As students and practitioners become more adept at performing, reading, and interpreting laboratory results and images, the temptation can be great to ignore the patient's

narrative in favor of the story told by the tests. Much cleaner than messy secrets that may challenge the student's own beliefs or personal values, the laboratory reports can feel morally safe and unthreatening.

The most difficult acknowledgement is the inherent existential understanding that, no matter how much the provider may try to control the body and bring its numbers back into alignment, it is ultimately contingent. The body will age; it will decay; it will die. Practitioners can stave off death for a time—for a long time even—but in the end, to ashes all go. The revolting sights or smells of the decaying, ill body remind the practitioner viscerally that he, too, is vulnerable, limited, and will one day die also. Secretions, wounds, and ulcers repulse and repel those who would touch the disturbed body. To turn away from that reality and attend to numbers and signifiers protects the practitioner from the existential dread of truly recognizing one's mortality.

The psychic weight of knowing the deep mysteries of the human and the reality of death can be so tremendous that they cannot be meditated upon for days on end. Practitioners, though, are bombarded with the actuality of human contingency on a regular basis. They are forced to reckon with the limits of medical and human knowledge each time their efforts are met with bodies that resist curative efforts. What a great burden we place on those who are also only human! As Kafka (2010) writes in his short story "The Country Doctor," the doctor–protagonist, harried and miserable, observes that his patients are "always demanding the impossible of a doctor. They have lost the ancient faith; the pastor sits at home, unraveling his liturgical vestments one by one. But the doctor is supposed to accomplish everything with his delicate surgical hand".

Embracing the technical aspects of medicine is a way to buffer practitioners from the burden of carrying all that secret knowledge, including the awareness of its limits. Machines provide a shield against the terror of truly being present with the contingent, fetid, sick body. By looking at the numbers, computer screens, and machines, as Dr. Cooley's health-care providers did, they can turn away from the reality of their potential impotence in the face of terrible disease while still *doing* something. Elevating the number over the primacy of touch, then, can be a protective mechanism on the part of the practitioner, but it is a perilous one that elevates the profane aspects of the medical encounter at the expense of the sacred interaction between two fully real persons. Physician–poet Raphael Campo's (1994) poem "Technology and Medicine" addresses how the practitioner's specialized technical knowledge can eclipse the shared experience of one human recognizing the humanity in the other.[1] The narrator's identity is permanently changed by the knowledge required to heal the sick body. The information acquired helps the healer do the work of fixing broken bodies, but the poem shows the emotionally harmful cost of that awareness.

The healer–narrator's technical competence dehumanizes him; in the poem it turns him into an amalgam of the machines he relies upon: microscopes, X-ray tubes, needles, and computer chips. Campo conflates the senses with the secrets he learns and the tools he uses. He writes, "My eyes/Are microscopes and cathode X-ray tubes/In one, so I can see bacteria,/Your underwear, and even through to bones." As a machine himself, the narrator has supreme, even omnipotent access to the intimate—underwear, blood, salt, and

[1] *The transformation is complete. My eyes/Are microscopes and cathode X-ray tubes/In one, so I can see bacteria,/Your underwear, and even through to bones./My hands are hypodermic needles, touch/Turned into blood: I need to know your salts/And chemistries, a kind of intimacy/That won't bear pondering. It's more than love,/More weird than ESP—my mouth, for instance,/So small and sharp, a dry computer chip/That never gets to kiss or taste or tell/A brief truth like "You're beautiful," or worse,/"You're crying just like me; you are alive."*

chemistries. He can feel the blood under the skin as his hands become needles, a tool that inflicts pain even as it helps the patient. When the narrator calls his mouth a computer chip, though, he laments the metamorphosis. He has lost the relationship of human being to another human being. With a computer chip for a mouth, he cannot tell his patients that he, too, is alive and cries. Because of his position and knowledge, he cannot "kiss, or taste, or tell/A great truth like "You're beautiful…." The power of medical insight has profane consequences on the provider. In this type of dyad, both provider and patient suffer.

Re-enchanting Touch of the Person

Even as practitioners protect themselves against the pain of contingency, vulnerability, and death, sick persons are experiencing their illness as whole persons, not disconnected from their bodies. As medical philosophers such as Svenaeus (2000) and Leder (2008) have argued, diseases are marked by more than just physical symptoms or numbers that fall outside of a proscribed range. Persons *experience* illnesses; in sickness, they inhabit a body that feels anything but regular, normal or mundane.

To be ill is to feel a sense that the body has turned from that which was taken for granted *into* something that is unfamiliar and uncanny. The body that in health could be presupposed suddenly becomes an object of intense concern. In health, a person has the capacity to consider or ignore her embodiment at leisure. A person can spend time noticing aspects of the body or simply go about their activities and pay physicality no mind. For the sick person, though, the body becomes foreign, distant, and *unhomelike* (Svenaeus 2000). The person may feel like a stranger to themselves, forced to constantly attend to the new perceptions that accompany the changing, ill body. The feelings of "unhomelikeness" may not be a sensation that can even be expressed with language, but rather something that is apprehended in a deeply internal way. In the memoir, *Cancer in Two Voices*, Butler and Rosenblum (1996) calls her body "unstable," as it turns into something alien to her. Affected by chemotherapy and radiation, she becomes unable to recognize her body's previous cues and signals. She describes the intimate connection between her body and her identity and the disruption caused by her cancer:

> What is it like to live in a body that keeps on changing? It's frightening, terrifying, and confusing. It generates a feeling of helplessness. It produces a slavish attention to the body. It creates an unnatural hypervigilance toward any and all sensations that occur within the landscape of the body…One loses one's sense of stability and predictability, as well as one's sense of control over the body (Butler and Rosenblum 1996).

The fright, terror, and confusion that Rosenblum feels can be exacerbated when the clinician recoils from the patient's sick body. Even considering its powerful properties, touching a sick body can challenge the practitioner's sensibilities. Fearing the complicated feelings that accompany touching a vulnerable human, the practitioner turns away, ignores it, and pretends that in avoiding the stigmatized body, she will be protected from the contingencies that mark her own life. The person—the self whose embodiment includes the wounded body—is also ignored. The human that lies beyond the sign is disconfirmed of her status as person.

Re-enchanting Medicine

We began this essay by describing an encounter experienced by a nurse-as-patient, where the power of touch was absent from her encounter. Instead, Dr. Cooley's caregivers relied on the machinery to provide evidence of her condition. Sadly, this experience is not unique. We have friends who noted visits with physicians for annual physicals that resulted in the absence of touch, not even to palpate the abdomen or feel lymph nodes in the neck. When asked about this omission, the physicians responded that they did not need to "feel" the body. Instead, they would receive all necessary information from laboratory tests. With this response, it is no surprise that some are calling for the re-enchantment of medicine.

We are not calling for the abolition of testing or the other advantages of technological medicine. The ability to "see" the workings of the body have vastly improved in the past decades and provide immeasurable benefits in diagnosing illness. Rather, we advocate for a re-imagining of the sacred and the profane elements of medicine by health professionals at all levels. Physical touch serves as a diagnostic tool, but more importantly, conveys an attitude of care and attunement. Thus, the choice is not whether to use technological innovations or touch, but rather to use both as elements of care.

Though those in medicine might like to bracket the spirit or the soul from its purview, to speak of persons requires that we consider those qualities that spark within each human and make them more than just meat and bones. The maneuverings of the soul cannot be quantified, but still erupt in the presence of radical ambiguity, vulnerability, and ultimate mortality. Accessing the shared benefits of touch provides a means of re-imagining medicine to return the focus to the patient as a person. The routine mechanical aspects of the clinical encounter allow the profane elements of medicine to take over and become tyrannical. Paradoxically, recognizing the numinous, sacred aspects of the clinical encounter can assist in bringing that sense of mundane normalcy back to the patient. Dr. Cooley's requests were simple and regular: a cool forehead rag and a hand hold. These small but powerful gestures would have reminded Dr. Cooley that she's not a thing; she is a person who, though suffering, continues to live. And while she lives in a body that feels foreign, it is the same body that has been with her since her birth.

By touching the sick body in a therapeutic way, the health-care practitioner resists the tyranny of the profane by reminding the patient of her *aliveness*. Touch lets the patient know that, even though her body may be changing, frail and sick, still she lives; still she matters; still it is good she is in the world. Therapeutic touch recognizes the patient as the "Thou" whose worth is inviolable. In the space where flesh meets, two humans encounter each other's personhood. Though the reality of illness persists, the practitioner affirms the humanity for both the patient and herself, opening up the space for a sacred awareness and even reckoning. By returning to the sense of touch, practitioners can resist the dehumanizing effects of machinery and re-enchant the profession in caring for persons they have sworn to serve.

Compliance with Ethical Standards

Conflict of interest Peggy L. Determeyer and Julie E. Kutac declares that they have no conflict of interest.

Human and Animal Rights This article does not contain any studies with human participants or animals performed by any of the authors.

Informed Consent Since the article does not contain studies with human participants, informed consent is not required.

References

Asadollahi, M., Jabraeili, M., Mahallei, M., Jafarabadi, M. A., & Ebrahimi, S. (2016). Effects of gentle human touch and field massage on urine cortisol level in premature infants: A randomized, controlled clinical trial. *Journal of Caring Sciences, 5*(3), 187–194. https://doi.org/10.15171/jcs.2016.020.

Baker-Rush, M. (2016). Reducing stress in infants: Kangaroo care. *International Journal of Childbirth Education, 31*(3), 44.

Butler, S., & Rosenblum, B. (1996). *Cancer in two voices*. Duluth, MN: Spinsters Ink Books.

Campo, R. (1994). Technology and medicine. *The other man was me: A voyage to the new world*, vol. 111. Houston, TX: University of Houston, Arte Publico.

Castiello, U., Becchio, C., Zoia, S., Nelini, C., Sartori, L., Blason, L., et al. (2010). Wired to be social: The ontogeny of human interaction. *PLoS ONE, 5*(10), e13199. https://doi.org/10.1371/journal.pone.0013199.

Cooley, S. (2016). *Nursing is a calling much bigger than charge capture*. TedXTWU, https://www.youtube.com/watch?v=v6iSTf7uMX0. Accessed 20 Jan 2017.

Edvardsson, J., Sandman, P.-O., Rasmussen, B. H., & universitet Umeå, omvårdnad Institutionen för, and fakulteten Medicinska. (2003). Meanings of giving touch in the care of older patients: Becoming a valuable person and professional. *Journal of Clinical Nursing, 12*(4), 601–609. https://doi.org/10.1046/j.1365-2702.2003.00754.x.

Eliade, M. (1987). *The sacred and the profane: The nature of religion*. New York: Harcourt Inc.

Kelly, M., Tink, W., & Nixon, L. (2014). Keeping the human touch in medical practice. *Academic Medicine, 89*(10), 1314.

Leder, D., & Krucoff, M. W. (2008). The touch that heals: The uses and meanings of touch in the clinical encounter. *Journal of Alternative and Complementary Medicine, 14*(3), 321–327. https://doi.org/10.1089/acm.2007.0717.

Nicholls, D., Chang, E., Johnson, A., & Edenborough, M. (2013). Touch, the essence of caring for people with end-stage dementia: A mental health perspective in namaste care. *Aging & Mental Health, 17*(5), 571–578. https://doi.org/10.1080/13607863.2012.751581.

Ozolins, L.-L., Hörberg, U., Dahlberg, K., & livsvetenskap Fakulteten för Hälso- och, Linnéuniversitetet, and vårdvetenskap Institutionen för hälso- och. (2015). Caring touch—patients' experiences in an anthroposophic clinical context. *Scandinavian Journal of Caring Sciences, 29*(4), 834–842. https://doi.org/10.1111/scs.12242.

Rousseau, P. C., & Blackburn, G. (2008). The touch of empathy. *Journal of Palliative Medicine, 11*(10), 1299.

Svenaeus, F. (2000). Das unheimliche–towards a phenomenology of illness. *Medicine, Health Care and Philosophy, 3*(1), 3–16.

Swinton, J. (2012). *Dementia: Living in the memories of god*. Cambridge, UK: Eerdmans.

Treadway, K. (2007). The code. *New England Journal of Medicine, 357*(13), 1274.

Verghese, A. (2009). A touch of sense. *Health Affairs, 28*(4), 1177.