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PARADIGMS

The Touch That Heals: The Uses and Meanings of Touch in the Clinical Encounter

DREW LEDER, M.D., Ph.D.,[1] and MITCHELL W. KRUCOFF, M.D.[2]

ABSTRACT

This paper investigates the healer's touch in contemporary medical practice, with attention to both allopathic and alternative modalities. Healing is understood as the recovery of an integrated relationship between the self and its body, others, and the surrounding world—the relationship that illness has rendered problematic. In this context, touch can play a crucial role in the clinical encounter. Unlike other modes of sensory apprehension, which tend to involve distance and/or objectification, touch unfolds through an impactful, expressive, reciprocity between the toucher and the touched. For the ill person this can serve to reestablish human connection and facilitate healing changes at the prelinguistic level. The healer's touch involves a blending of attention, compassion, and skill. The clinical efficacy of touch is also dependent upon the patient's active receptivity, aspects of which are explored.

All too often, modern medical practice is characterized predominately by the "objectifying touch" of the physical examination, or the "absent touch" wherein technological mediation replaces embodied contact. This paper explores the unique properties of touch as a medium of perception, action, and expression that can render touch a healing force within the clinical encounter.

INTRODUCTION

In many cultures and historical periods, physical touch has played a central role in healing. Jesus is portrayed as curing fever, leprosy, and a child at the point of death through the medium of his touch; a woman's chronic hemorrhages ceased when she but touched his garment (Mark 1:30–31, 40–42; 5:25–42). Such Biblical examples illustrate a power utilized in many societies by lay, spiritual, and professional healers alike, ranging from those of lowly status, such as the women healers persecuted during the European witch trials, to the kings of France and England whose magical touch was said to relieve scrofula, epilepsy, and a diversity of other ills.[1,2]

Touch is so central in healing work that it comes metaphorically to stand for the whole enterprise skillfully performed. "She has the healing touch," we say. Yet what specifically does healing have to do with touch? What is it about human touch, ever poised among movement, expression and sensing; empathy and objectification; the soothing, stimulating, and invasive, that makes this gesture a powerful medium of healing?

DISEASE, ILLNESS, AND HEALING

To understand the healer's touch we need first to address the notion of healing itself. This in turn leads back to an examination, albeit briefly, of that which needs to be healed.

[1]Department of Philosophy, Loyola College in Maryland, Baltimore, MD.
[2]Department of Medicine/Cardiology, Duke University Medical Center, Durham, NC.

Philosophers of medicine have distinguished between "disease" and "illness."[3,4] Modern medicine has been largely concerned with treating diseases, for example, pneumococcal pneumonia or myocardial infarction. Disease classification does not focus on the individual so much as patterns, generalized across the population, of characteristic anatomical or physiological lesions and their associated symptom-clusters. The disease label also ideally invokes an explanatory etiology, a prognostic outcome, and a set of treatment options, all drawing upon the theories and knowledge base of medical science.

In contrast to such medical characterization of disease, the term "illness" is used to refer to the experience of the sick person. One suffering from acute myelocytic leukemia is not simply a repository for the disease entity. He or she is undergoing an *illness*, a painful and dislocating transformation of customary life. "Health" shares the same etymology with the word "whole," and in health the body, self, and world form a dynamic whole integrated in equilibrium. This is precisely what illness disrupts, bringing about a multifaceted *dis-integration* of relations.[5] While specifics differ with each individual and syndrome, some generalities can be sketched of the characteristic disharmonies introduced by illness.

My own body is ordinarily the unproblematic medium through which I experience life. This body is not simply something I have, but *who I am*, grounding my interactions with the world, my capacities for sensation, expression, and action.[6–8] Yet when I fall ill, this body can surface as something alien.[9–11] My own body is now revealed as potentially traitorous, that which can cause me pain, limitation, and humiliation. Cartesian mind–body dualism, while problematic as metaphysics, speaks to the experience of the ill person sensing the body-as-other.[9]

This dis-integration of the self-body relation is accompanied by breaches in the relation of self and the spatiotemporal world. A flight of stairs in one's own home now looms like an unscaleable mountain. A destination once easily reached now recedes to the unattainable. Inhabited space can close down centripetally to the confinements of sickbed or hospital. Time too becomes disrupted and distorted. Minutes pass slowly like hours. Hopes for the future lie wrecked by incapacitating or fatal illness.

This dis-integration between self and body, self and world, is often accompanied by a dis-integration between self and others. In any number of ways, illness can isolate. The sick person may be unable to participate in work and social routines, or may choose to withdraw due to weakness or disfigurement. Then, too, the pains of illness are often consummately private. They take place within the confines of one's flesh and are difficult to translate into public language.[12] Moreover, others may withdraw from the ill person, not wishing to be reminded, sitting by sickbeds, of their own mortal vulnerability.

Understanding illness as a multifaceted experience involving dis-integration and dis-equilibrium now enables us to better characterize "healing." It should not simply be equated with disease cure, which may or may not prove feasible. Rather, a healing process is one that enables the ill person to re-integrate, to recover mind-body-spirit-world equilibrium, to become more whole, even if there are ongoing physical and existential challenges,[3,13] A patient with rheumatoid arthritis can learn how to care for her body and skillfully cope with its limitations. Technological assists may help her negotiate the physical world. A network of caring providers, and family and friends, as well as others afflicted with the same disorder, may give support. Psychospiritual meaning can be found even in the midst of suffering whether through the example of Christ on the cross, Buddha's mindfulness, or other religious and existential models. All of these may thus serve as healing influences even if the medical disease progresses.

The clinician can act as healer through any number of ways—skilled diagnosis, explanation, and treatment of the disorder; exercise of compassion; provision of psychologic support; and/or summoning together of a social network. At the same time, the contemporary medical system can also make things worse. The patient's experience of confusion, alienation, powerlessness, and isolation can be exacerbated when he or she is examined by an insensitive physician, or when admitted to the modern hospital, banded, and disrobed in a way that may prove dehumanizing.[14]

THE OBJECTIFYING TOUCH AND THE ABSENT TOUCH

With this in mind, and before turning to the touch that heals, we reflect briefly on two aspects of the phenomenon of touch prevalent in contemporary medical practice—the objectifying touch and the absent touch.

Since the late eighteenth century, disease classifications have become progressively less based upon patient reports of symptoms, and more upon the pathologic lesions and mechanistic processes exposed in the corpse, or in the living by medical examination and diagnostic technologies.[15,16] Hence "dyspepsia"—digestive discomfort—comes to be replaced by "peptic ulcer disease," with objectively observable lesions. The cadaver and its physioanatomical components which, when opened and probed, reveal such hidden secrets, becomes medicine's epistemic touchstone, the "ideal patient" so to speak.

We see this "advance" reflected in the physical examination, which gained ascendancy in the nineteenth and twentieth century.[2] The patient largely assumes a corpse-like pose beneath the physician's probing eyes, ears, and fingers.[17] The practitioner's discerning touch seeks out pulses, nodules, inflamed tissue, abnormalities; checking for size, warmth, hardness, and other observables. From time to time,

the patient may be asked "does this hurt?" but otherwise mainly lies inert, a body to be explored by the objectifying touch, and other modes of sensory investigation.

Historically the physical examination came to be viewed as providing more objective and therefore reliable data than "subjective" patient accounts of symptomatology. In more recent times, the physical examination has been even further superceded as a "gold standard" by diagnostic technologies such as X-ray and ultrasound images, electrocardiograms, and blood tests.[18,19] While medical schools still emphasize the critical nature of information derived from history and physical examination, actual practice patterns convey that information gathered at the bedside is always limited and questionable. The doctor's senses cannot reach fully into the patient's interior and may miss or misinterpret surface features. Technological diagnostics can seemingly overcome these limitations, providing highly detailed information concerning visceral, microscopic, and biochemical bodily processes. They can often generate data in mathematical form, which, since the time of Galileo and Descartes, has been seen as the true language by which science deciphers nature.[20] Laboratory values, or the images produced by sophisticated devices, can also be compared over time and across populations, examined by independent observers, and archived as medical records. Of course, such laboratory and imaging studies are also well-reimbursed.

Historically, then, we perceive a trend from an objectifying touch to the all too frequently "absent touch" of modern medicine. Direct doctor–patient contact gives way to a reliance on intermediate devices that help diagnose, and later treat, the patient technologically. These are often seen as improvements, or even miracles, of health care. An archetypical scene results: The doctor strides into the hospital room and, rather than reach toward the patient, reaches instead for the chart containing the latest laboratory results.

Maintained in a larger healing context, objectifying touch and technologies both make practical contributions to the healing arts. Most patients, when seriously ill, would surely want a careful physical examination and appropriate diagnostic tests. Problems arise, however, when these modes of "touch" become dominant and emblematic within the clinical encounter. They then have the power to exacerbate, rather than heal, the dis-integrations typical of the experience of illness.

The objectifying touch, for example, can exaggerate the patient's sense of alienation from the body. He or she is asked to remove clothing; expose flesh for probing, squeezing, poking, and measurement, all in search of pathologic features. While clinically revealing, this can be personally alienating, confirming the patient's sense of having a distressingly flawed object for a body.

It is not merely the self–body, but the self–other relationship that can be further disrupted by objectifying touch. Bridging the physical and emotional gap between people, touch is a medium through which we directly express care, comfort, and compassion. In exactly this regard, the objectifying touch can prove a harsh disappointment. It is not primarily communicative or empathic, but analytical. This touch does not represent what Buber termed the "I–Thou" moment, a dialectical contact between two subjectivities.[21] Rather, we have what Buber called the "I–It" stance of the sort employed when encountering a thing. Ironically, this comes at exactly the moment when the sick person may feel particularly vulnerable and thing-like, most in need of human contact.

Of course, a certain amount of objectification is necessary, even beneficial, in the clinical encounter. It is also important to avoid inappropriate intimacy which can violate boundaries, damaging both clinical judgment and patient trust—we are all aware of the possibility of professionals abusing their positions and committing sexual indiscretions. At the same time, confining the professional to the purely objectifying touch can heighten the patient's sense of alienation.

The "absent touch" of purely technological medicine is little better.[22] Here, human touch is eschewed altogether in favor of human–technology interfacing. Poked with needles, inserted into computed axial tomography scans, hooked up to electrodes, the body is annexed to a world of machines. The illness has already rendered the body something foreign, uncontrollable, unpleasant; now "high-tech" medicine intensifies this experience. Just when one most longs for the "personal touch," it is least forthcoming.

THE PHENOMENOLOGY OF TOUCH

How is it that touch, or the absence thereof, has such special abilities to heal or worsen the disruptions of illness? What, after all, *is* touch? Having sketched a brief phenomenology of illness, it is now important to do the same for touch as human capacity.

When viewed as one of the five senses, "touch" actually includes within it a bewildering diversity of sense experience, including that of the internal proprioception of visceral and musculoskeletal systems, as well as receptivity to external heat, pressure, and vibratory patterns bringing pains and pleasures, with the body surface functioning as a massive sensing organ. We will here confine our attention to a more limited phenomenon, the sort which manifests in a clinical setting: intentional human touch directed toward the world in ways designed to be exploratory and/or efficacious. We will briefly outline three defining characteristics of this mode of touch: it is *gestural*, *impactful*, and *reciprocal*.

Calling touch gestural in itself highlights a number of features. To see or hear something, it can be sufficient to wait motionless, with photons and sound waves impinging from without.[23] By contrast, touch, when used to explore the world, relies upon an active movement, a gesture. It is in

reaching out, pushing, probing, and stroking, that the hand solicits sensory information. Moreover, this action needs to be varied and renewed to keep touch alive; tactile receptor response "accommodates," generally diminishing over time to unchanging stimuli.

Touch is "gestural" not only in the sense that it implies activity and activation, but that it therefore also bears within it expressive content. Whether I probe an injury, finger a soft linen, stroke a cheek, or punch someone with a fist, these are actions which embody gestural significance, be it investigatory, amorous, or hostile in nature. The body manifests meaningful intentionality that may or may not be fully conscious and articulable.

Touch is not only gestural in such ways, but impactful. That is, it depends upon the physical impact, contact, of one body with another. In the senses of sight and hearing, perception takes place across a distance. Sight in particular tends toward the distanced, objective, and theoretical consciousness.[24] Hence, many of our metaphors for knowledge—gaining "insight," or "shedding light" on a matter—are related to vision. However, as Jonas writes, "touch is the sense, and the only sense, in which the perception of quality is normally blended with the experience of force."[24]

The physical force of touch can also be associated with cognitive and emotional force. This explains the great cultural significance attached to the loving or consoling touch, the sexualized touch, or the invasive and hostile touch, all of which are carefully regulated by social codes.[25] The impactful nature of touch is great enough to provide a general metaphor for emotionally powerful events: "I was really touched by that," we say, or "I felt it deeply."

Finally, touch is not only gestural and impactful, but reciprocal. To touch another is, in turn, to be touched back. Whether I press against the flesh of a person, or the surface of an inanimate object, I feel it pressing back on me. Tactility is bidirectional in a way not true of sight or sound where the watcher or listener may be distanced and hidden from the other. Such is impossible given touch's intimate mutuality. Hence, touch is used as a metaphor for social connection: "I'm back in touch with her," we say, that is, once more "in contact."

Touch can also be understood as "reciprocal" in a different sense; it involves a reflectivity not only between two bodies, but between two dimensions of one's own embodiment. Taking place largely at or near the body surface, touch reaches outward to sense the world. At the same time, physical contact can provoke a stream of proprioceptive sensations that make us more aware of our own embodiment. In an amorous caress, we awaken not only to the other's body but to our own, with its sexual impulses and pleasurable sensations. Vision, the objectifying sense par excellence, seems to yield a detached register of what lies outside. Touch's intimacy of contact can make us aware of the reciprocity of inner and outer, as well as that of body and world, self and other. Rather than perceiving the world across a distance, touch is almost literally defined by the surrender of boundaries and the adoption of relational intimacy.

THE HEALER'S TOUCH

We are now in a better position to understand the crucial roles touch can play within the clinical encounter. We earlier characterized healing as a response to the multiple disintegrations of illness. Touch, with its unique properties, can assist a multidimensional re-integration.

First, touch can serve as a way to reaffirm the connection between self and other that may have been disrupted by the pain, incapacities, and disfigurements of illness, as well as the objective or absent touch characteristic of modern medicine. When a healing practitioner touches a patient with attention and care this gesture has impactful meaning, demonstrating reciprocity, vulnerability, and the intent to help.

Rendering this gesture even more important is the fact that illness can bring about an understandable psychic and physical regression. When injured children, we longed for hugs, our bruises to be kissed and bandaged, and our tears wiped away. In the womb and early childhood, we inhabited tactile worlds, embraced in circuits of intercorporeity that sustained us in the face of threats. When seriously ill, we are there once more, yearning to be touched.

But what distinguishes the touch that heals? For one, it is the expression of compassion.[26] Etymologically, "compassion" means "to feel or suffer with." A practitioner cannot take on all the suffering of others or that practitioner would soon be overwhelmed. However, compassionate touch is that which encounters the other not simply as object, an "It," but as a subject, a "Thou" with whom the practitioner can identify. The compassionate therapist therefore is careful not to cause undue pain or humiliation when conducting a physical examination. She or he understands this is a human being in distress, not simply a lesion to be probed. Careful touch is enfolded in a communicative relationship wherein the practitioner may verbally explain what is being done, and why, and what the findings signify, even while eliciting comfort and confidence through the medium of touch itself.

Given the impactful and reciprocal nature of physical touch, the therapist implicitly consents to be "touched" by the encounter. The practitioner's own life experiences of woundedness, be it of flesh or spirit, can open the heart and sensitize the touch, turning a "health-care provider" into more of a healer.

Yet we want more than just compassion embodied in the clinician's hands; we also want skill and expertise. Precisely because touch is impactful, we wish to make sure our provider knows what he or she is doing. Hitherto, this paper has focused on diagnostic touch, emphasizing tactility

as a mode of sensing. However, we have also identified touch as a gesture, an impactful action; it can thus be incorporated into many modes of treatment in a way sight, hearing, smell, and taste could not. Here the very division between "diagnosis" and "treatment" often falls away. Even taking a pulse with care and sensitivity becomes part of an ongoing tactile dialogue between healer and patient, capable of altering the bodily states being examined.[27]

In such a way, touch is used in a wide variety of alternative and complementary healing practices, as well as in more conventional medical therapies. For example, chiropractic, physical therapy, various techniques of massage, bodywork modalities such as Feldenkreis and the Alexander Technique, acupressure, energy therapies (which can also employ "touch at a distance") including Therapeutic Touch, Healing Touch, Reflexology, Reiki and certain kinds of *qi gong*, are but a few practices in which touch plays a central role in a variety of specific ways that merit further exploration.

Again, such interventions can help relieve the self–other breach typical of illness. If I am a suffering client, I discover that the practitioner is not only compassionately attentive to my sufferings, but actually can relieve them. I feel again the power and empowering nature of my embodied connection to others.

Second, and as importantly, the cleavage I feel between self and body is bridged. In illness, my own body surfaces as something painful, incomprehensible, uncontrollable, and hence alien. Now the skillful hands of the healer help forge a reconnection. Supplementing my own powers, they begin to restore my ability to understand and make an impact on my physiology. The expert fingers of the masseuse relax my tight muscles and ease my pain; the chiropractor realigns my contorted spine; and the Alexander Technique teacher uses hands to help guide my body to habits of natural movement that heal, and prevent further, injury.

Frequently, that which begins simply as external manipulation becomes a tactile conversation which helps me learn to inhabit my body in new ways. As discussed, touch is "reciprocal"—I feel not only the touch of the other, but the sensations and responses that well up from within my own body. I thus gain greater proprioceptive self-awareness, and can begin to influence my own states of musculoskeletal tension, the flow of energies, the characteristics of my posture, and even of visceral functioning. We say that I grow "more in touch" with my body, a statement midway between literal and metaphoric truth. Illness robbed me of a sense of agency and reduced my body to a theater of pain. Now I learn of powers, pleasure and possibilities of which I may have been hitherto unaware. Gradually, the effects of the other's healing touch become "in-corporated," brought within my own embodiment.[9]

Could such have been effected by verbal directives? Not necessarily. The body often has deep-set and preconscious modes of expression showing forth in habits of contraction, hypervigilance, collapse, or imbalance. Illness may not only be the result of these patterns but that which further intensifies them, generating a negative cycle of frozen or progressive dysfunction. The medium of language may be insufficient to break such preconscious patterns, as well as difficult to process at a time of illness and acute distress. The gestural, impactful, reciprocal nature of touch speaks in terms the flesh may better "grasp."

We see this prelinguistic healing power of touch demonstrated in many human encounters and from the very beginning of the lifecycle. For example, skin-to-skin parent–child contact (so-called "kangaroo care"), and modes of massage, have been shown to help infants and preterm newborns variously gain weight, decrease stress and heart rate, sleep better, and neurodevelopmentally mature.[28–30] It is even possible that some of the stress-related diseases endemic within our culture are partially rooted in a relative deficit, throughout the lifecycle, of intimate and consoling touch. These diseases may remind us of the human need to get "back in touch" with one another and ourselves, or else suffer.[31]

In helping heal the breach between self and others, self and body, touch also reintegrates self and world. Transformations of the inner body correlate with new possibilities of perceiving and acting. Take, for example, a woman whose severe arthritis is helped by massage. She recovers an "increased range of motion" not only in terms of joint mobility but enhanced capacities to focus on others, engage in activities, and traverse lived space and time. Her world has expanded outward, even as healing touch penetrated within.

RECEPTIVITY TO HEALING

We have been focusing on the healer's touch as informed by compassion, skill, and expertise. However, the patient's role cannot go unappreciated. To do so would be to fall into a stance, like that of medicine's objectifying or absent touch, which reduces the patient to a thing. The reciprocal nature of touch reminds us otherwise; the patient is not just an "it" but a "Thou," an active partner in healing. We must honor and explore this contribution.

The very term "patient" can here be both misleading and revealing. From the Latin root "pati" meaning to "suffer, feel, or endure," "patient" is closely related to the word "passive." Hence many practitioners and theorists eschew this term; it can seem to characterize the ill person as but the passive object of the therapist's agency. However, to be "patient" has other meanings. It is, for example, a primary religious and cultural virtue suggesting not so much passivity as an active ability to endure waiting, suffering, challenge, based on a fundamental optimism concerning the processes unfolding and the benevolent powers of the universe.

This can point us toward attitudes that enhance receptiv-

ity to healing touch. Hope is an important element. To open a wounded body to the impactful touch of another involves a leap of faith, a hope that healing, if not cure, is surely possible. For those with chronic, seemingly intractable conditions, this is no easy matter but essential for treatment to proceed. It is hope that enables the patient to *be patient*, enduring the embarrassments of exposure, the invasive touch of another, the pains and discomforts this might elicit, the length of time needed for the body to incorporate new habits, the advances and setbacks one meets along the way.

The receptive body is not only one that is hopeful and patient, but actively engaged with the treatment. We have said that touch is gestural, impactful, reciprocal. To be maximally effective, touch must be received in this spirit. The patient opens to the impact of the chosen mode of treatment, and adopts the recommended gestures, whether these involve muscle relaxation, visualization, focused sensory awareness, and/or styles of movement. The body aligns reciprocally with the practitioner's touch and suggestions. This then allows an unlocking of the body's own innate wisdom. The skillful healer may not so much impress a fleshly change from outside, as invite, release, and support an expression of the ill body's own potential for healing. The readiness of the patient to engage in this process is just as important as the therapist's expertise.

In this relationship, the patient assumes what might paradoxically be termed "an engaged surrender." The patient exercises active will, but not in an egoic style which values autonomy and self-assertion above all. To be open to another's touch involves surrender of that posture whose insecurities and rigidities may itself be a cause of illness. One consents instead to be open, guided, touched—literally and metaphorically—by the hands of the healer. It is recognized that the healer may "reach" something or somewhere that the patient cannot alone, and the patient has to surrender to that process.

Physiologically, this often manifests in a state of relaxation. With muscles held tight, glands secreting fight-or-flight hormones, we are not most receptive to touch. In the deepest sense, relaxation is not just a physiologic but ontological state. It represents an embodied faith that the universe is not simply constricted and threatening, but that to which we dare open in trust. Relaxing to the touch, we reclaim a sense, perhaps reaching back to prenatal experience, of being part of an embodied circuit of connection that would care for us, not do damage. This element of return is suggested by the word itself: To "relax" etymologically means to "loosen back," or "loosen again." Relaxation is not simply an adjunct to healing touch. It itself is a potential channel of healing, re-integrating self with body, others, and world.

Given the level of openness called for by healing touch, the patient does well to be judicious. Hope, patience, engaged surrender are all to the good but only if exercised with discernment. Intellectually, we can explore the different treatments available and their efficacy given our conditions. Intuitively, our bodies may come to know which healers to trust, whose hands have the "magic touch," with which persons or practices we will best be relaxed, receptive, and engaged. We need, that is, to be in touch with ourselves to decide who else shall touch us.

This is not, then, conventional medicine's ideal of the "good patient" who submits passively to whatever the doctor prescribes. Nor, however, is this exactly the counter-ideal of the assertive patient managing treatment step-by-step. While it may be of benefit when negotiating the overspecialized and financially-driven world of modern medicine, an aggressive, egoic stance can armor us against receiving the healer's touch. In the right situation, judiciously chosen, we must reclaim the capacity to trust, surrender, receive, engage in an intimate embodied dialogue. Ultimately the touch that heals is not something the clinician does, or the patient. Touch ever unfolds in the space between, embodying the wholeness of the I–Thou relationship.

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Address reprint requests to:
Drew Leder, M.D., Ph.D.
Department of Philosophy
Loyola College in Maryland
4501 North Charles Street
Baltimore, MD 21210

E-mail: dleder@loyola.edu

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