Exposed Intimacies
Clinicians on the Frontlines of the COVID-19 Pandemic
Ellen Block

ABSTRACT: COVID-19 has overwhelmed health-care providers. The virus is novel in its prevalence, severity and the risk of asymptomatic infection. In order to reduce the risk of infection and stop the spread of COVID-19, clinicians in hospitals across the United States are taking measures to limit exposure to infected patients by reducing the frequency of visits to patients’ rooms, touching patients less, and adopting new protocols around the use of personal protective equipment (PPE). While these newly adopted practices are helping to reduce transmission risk of COVID-19, they are producing a habitus of infection; an acute shift among clinicians that is deeply embodied and likely to have a permanent impact on the health and wellbeing of both providers and already isolated patients.

KEYWORDS: care, COVID-19, embodiment, habitus, clinicians, medical anthropology

COVID-19 is novel in its breadth, severity, long incubation period, the risk of asymptomatic transmission, and the many uncertainties surrounding the new disease. Health-care providers fear being infected and acting as inadvertent vectors of infection. In order to reduce this risk, clinicians are limiting the time and frequency of visits with their patients and are reducing physical touch from their clinical encounters. Yet they feel deeply ambivalent about these safety measures, which put physical and affective distance between them and their patients. While these newly adopted practices are helping to flatten the curve of COVID-19, they also reveal the ways that bodily proximity and intimacy between clinicians and patients have always been essential to clinical encounters, and challenge health-care providers’ ability to provide compassionate care to already isolated patients.

Pierre Bourdieu’s (1977) notion of habitus is a key to understanding the embodied experiences of clinicians and patients during COVID-19. Habitus refers to a practised set of repeated ‘mundane bodily practices’ (Lock 1993: 137), which produces regularities. In other words, subconscious everyday habits that result from one’s everyday experiences engender specific embodied ways of being in the world. Medical anthropologists have long noted the importance of embodiment in terms of a patient’s experience of illness, but have also noted that the embodied disposition of health-care providers has social significance (Cooper 2015; Livingston 2012; Smith-Oka 2012). Interestingly, health-care providers often use the term ‘body habitus’ to discuss the bodily changes of their patients as a result of disease. However, these same clinicians have typically paid little attention to their own body habitus, or the ways in which their own bodies impact – and are impacted by – the clinical encounter. The concept of habitus normally gestures towards the deeply situated bodily practices that people do without even thinking about them. But COVID-19 is radically altering health-care providers’ bodily awareness in new ways. In the context of COVID-19, a clinician’s limited interactions with patients, the physical barriers erected to reduce risk of disease transmission, and the limited use of touching create what I call a ‘habitus of infection’.

Borrowing from Vania Smith-Oka’s work, which examines how social inequality and blame in clinical
encounters produce a ‘reproductive habitus’ of risk amongst pregnant women in Mexico (Smith-Oka 2012), a habitus of infection calls attention to the relationship between health-care providers’ embodied practices and their sense of risk based on the presumed infectiousness of the patient’s body. The stakes of these new kinds of clinical encounters are significant. As Annemarie Mol emphasises, there are moral implications to the ‘practical activities’ that constitute care (2008: 75). Based on in-depth ethnographic interviews with 55 doctors and nurses working in US hospitals conducted between April and September 2020, I argue that COVID-19 distances clinicians from their patients in order to protect them, producing an acute shift that is deeply embodied and likely to have a permanent impact on the health and well-being of both providers and patients.

Isolated Patients and the Habitus of Infection

Health-care systems have instituted policies that leave patients alone for much of the time. Most hospitals are not allowing visitors, even for non-COVID patients, though some have recently allowed one or two family members into non-COVID units or when a patient is dying. Hospitals are also limiting the interactions clinicians have with patients in order to reduce the number of risky encounters, to preserve limited personal protective equipment (PPE) such as N95 masks and gowns, and to save time donning and doffing PPE. While clinicians are making adjustments in order to avoid being a vector of transmission, they are becoming increasingly aware of the ways that their previous practices hinged on sociality and physical contact with their patients.

Most of the clinicians I spoke with said they cluster tasks in order to reduce the frequency of visits into a patient’s room. Quite literally, this adjustment alters their spatio-temporal use of their bodies while at work. Dillon, an emergency room (ER) nurse in Chicago, Illinois, said she spends an hour or more with new COVID patients in order to do as many intake tasks as possible, then writes her number on the whiteboard in the room and tells the patient not to press the call button, as the latter requires a physical visit. When possible, clinicians speak with their patients on the phone, so patients are often left in their rooms alone for long stretches of time. Several nurses from different hospitals told me that they have rigged up tubing under the door to avoid entering a patient’s room when changing an IV bag.

These practices, while protecting clinicians from infection, have also called attention to the psychological and emotional cost to patients. Many clinicians expressed concern with the extent of their patients’ isolation and have found ways to improvise in order to connect with patients safely. Dillon noted: ‘The doctors started to just stand outside the door and talk to them on the telephone, which I think is really nice. They’re using their personal cell phones so [the patients] can see them’. Olivia, an attending ER doctor in Denver, Colorado, said she would normally drop into a patient’s room to check her residents’ work and chat, but now she only does that when necessary. Instead, she waves from the door. Health-care providers’ sensibility around infection has drawn attention to risks of transmissibility, but their discomfort with the potential negative health effects on patients are foregrounded through these new practices of communication. A heightened awareness of patients’ psychological distress is a dimension of this new habitus.

Health-care providers also have limited interactions with patients’ families, which is an important component of establishing intimacy and rapport with a patient and their support network. Usually, families are present when doctors do rounds, so they are kept up to date on the patient’s condition and care. Due to COVID-19 visitor restrictions, many doctors and nurses expressed phone fatigue, as they spend a great deal of time calling family members in order to provide updates and make critical decisions about intubation and end-of-life care. Quinn, an ER doctor in Rhode Island, volunteered to work in one of New York City’s inundated hospitals during the height of the COVID-19 peak in April 2020. She said at that time there was very limited communication with families because, she lamented, ‘there was sort of a hierarchy of needs in that situation that precluded going through all the ideal steps that you would take if somebody was dying’. During that busy period, she noted that her time was better spent on patient care than on the phone with families.

In most hospitals, however, staff attempt to reach family members by phone or video chat to keep them informed. Kate, an ICU nurse in Madison, Wisconsin, said she has witnessed many last conversations between patients and their families. She said: ‘Our hospital did buy a few iPads to help facilitate some of that [communication]. I’ve held phones up to patients’ ears as they’re dying and their family is not able to get there in time to say goodbye’. Leo, a third-year ER resident in Denver, described a woman who brought her father into the hospital. His breathing
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Making Sense of Touch

Anthropologists rely heavily on visual descriptions

of what they encounter (Stoller 1989), yet touch is

also an important area of enquiry both as a signifi-
cant social practice (Classen 2005; Thayer 1982) and

as a crucial component of clinical encounters (Blake

2011; Livingston 2012; Rasmussen 2006). Due to

COVID-19 policy changes, clinicians are physically

touching their patients as little as possible. Leo said

he no longer does standard physical examinations

that have ‘no benefit’ if they would not change the
course of action for a COVID patient. Kate, an ICU

nurse, lamented her inability to comfort patients

through physical touch. She said:

I’m used to caring for patients who are ventilated

and have limited communication, but I’m used to be-
ing able to hold their hand and smile and show my

face, whereas now I’m covered in a face mask, I have

a gown from head to toe; I have to wear gloves all the
time. I can’t even touch them, which doesn’t give you
the same kind of healing presence.

Quinn, the ER doctor from Rhode Island, also re-

curred on the feeling of isolation that her PPE might

engender:

I imagine it’s nice to have somebody there holding
your hand. Just some kind of human contact when
you’re feeling scared. But with COVID your family
can’t come in. If somebody comes over to hold your
hand that person is wearing a mask and goggles
and gloves and a gown. There’s just an extra added
barrier between you and other human people, you
know? I just imagine it feels very lonely.

Molly, an ICU nurse who worked for a time in a

COVID unit in Wisconsin, said she and her col-

leagues frequently discussed the challenges of avoid-
ing physical contact with patients. She added: ‘If I
have a patient who’s in pain, they’re sad, or whatever,
I’ll make a point to take my gloves off and hold their
hand in normal circumstances, because gloves are
a barrier to real human touch, and I really firmly
believe that real human touch helps people’. Clearly,
many of the clinicians I spoke with recognise that
contact and connection are good for healing. Given
the inability to perform mundane rituals of inter-
connection in the clinical space, like chatting with a
patient while changing their IV fluid or holding their
hand when delivering bad news, medical practitio-
ners are reminded in an even more acute and embod-
ied way that healing works better through vectors of
social interaction.

Embodying Risk

New protective protocols are being embodied and in-

ternalised by health-care providers. PPE adds to the

lack of intimacy between clinicians and patients by

vastly reducing important ways of establishing con-
nection such as skin-to-skin touch, eye contact and
facial expression. Most clinicians found PPE painful,
stressful and a constant reminder of the risk of infec-
tion. As Alex, an ER nurse in suburban Minnesota, told
me: ‘The masks, when you’re breathing your same
CO2 over and over again, it gets very hot and your
goggles are fogging up so you don’t see clearly . . .
I just open up my windows on the way home from
work, and just breathe the fresh air to try to settle
myself down’. Like Alex, many clinicians made the
explicit connection between the PPE protocols and
higher levels of fear, anxiety and stress for patients
and providers. Molly, an ICU nurse, told me that she
felt safe enough while in a COVID patient’s room
because she was appropriately covered, but outside
the room she was unsure how to protect herself. She
described the uncertainty she felt when a nurse inside
a COVID patient’s room handed her a lab sample:

You’re thinking constantly about, well, that bag the
lab is in was in that patient’s room. What did it touch?
The nurse’s glove, what did it touch? And now there’s
conflicting data on whether or not [COVID] lives on
surfaces and how long. It’s like, well do I wear gloves
when I grab that bag, or not? Do I need to put it in
another bag to make sure I’m not contaminating the
tube system when I get it to the lab? I don’t know. So,
it’s the tiniest things that you never thought about,
that you’re constantly having to think all the time . . .
I always felt hesitant to touch anything or go any-
where near anything. I was tense all the time.

Quinn insightfully analysed her PPE in relation to the
pandemic more broadly. She said: ‘The experience
and the tension of going [to work] is different . . .
There’s this sort of visceral experience in your body
which, I feel like PPE really is sort of metaphorical,
you know. It’s like the externalisation of the discom-
fort of the whole situation’. Bourdieu’s notion of habi-
tus calls attention to the durability and internalisation
of embodied dispositions. What these reflections indi-
cate is that a totally new set of embodied dispositions
can emerge quickly when people are under duress,
and clinicians have a heightened awareness of them.

Conclusion

Writing about Ebola, Sung-Joon Park and René Um-
lauf ask: ‘What does care mean when closeness, inti-
macy, and sociality must be avoided?’ (2014). COVID-
19 raises similar yet also new kinds of challenges
around care. The disease is novel in its scope and
scale, but also in the ways its insidious invisibility
through asymptomatic infections causes anxiety for
practitioners who are worried about getting sick and
unknowingly infecting others. Thus, clinicians have
adopted embodied practices – what I have called a
‘habitus of infection’ – that necessitate removing
intimacy and affective connection between provid-
ers and their patients. Also emerging is a new self-
consciousness around embodied modes of caregiving
that had hitherto been taken for granted. While habi-
tus normally implies embodied dispositions that we
do without thinking about them, a habitus of infection
causes both a change in embodied practices and a self-
consciousness about them that reflects the constant
bodily awareness that COVID-19 necessitates. Many
clinicians worry that some of these practices that
reduce interaction and human connection with their
patients are likely to be permanent. It is important to
consider not only the clear risk-reduction benefits of
adopting these measures, but also how they impact
the experiences of clinicians and patients and how
they transform social relations in the clinical space.

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Note

1. This research has IRB approval and is part of an
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