

Exposed Intimacies

Clinicians on the Frontlines of the COVID-19 Pandemic

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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.¹

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

was extremely laboured, and he needed intubation. Leo recalls telling his daughter: 'I'm sorry. I have to have you leave the hospital and go stand by your car in the parking lot and I will try and find you in a few minutes and make sure you know how the intubation went'. Afterwards, Leo wandered around the parking lot calling for her for several minutes to inform her that her father was in critical condition but she would not be allowed to see him. Stories of isolated patients and families anxiously awaiting news are too numerous to recount here. Isolation is clearly one of the defining characteristics of the COVID-19 pandemic for patients, perhaps the most frightening one. Health-care providers' acute awareness of their patients' isolation draws attention to their own embodied experience in distancing themselves from their patients, and they find it troubling.

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 significant 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 being 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 reflected 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 colleagues frequently discussed the challenges of avoiding 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 interconnection in the clinical space, like chatting with a patient while changing their IV fluid or holding their hand when delivering bad news, medical practitioners are reminded in an even more acute and embodied way that healing works better through vectors of social interaction.

Embodying Risk

New protective protocols are being embodied and internalised by health-care providers. PPE adds to the lack of intimacy between clinicians and patients by vastly reducing important ways of establishing connection 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 infection. 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 anywhere 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 discomfort of the whole situation'. Bourdieu's notion of habitus calls attention to the durability and internalisation of embodied dispositions. What these reflections indicate 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 Umlauf ask: 'What does care mean when closeness, intimacy, 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 providers and their patients. Also emerging is a new self-consciousness around embodied modes of caregiving that had hitherto been taken for granted. While habitus 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.

Acknowledgements

I am grateful to D'Havian Scott, Mackenzie Carlson and Grace Savard for their invaluable support, and

to Bianca Dahl and Megan Sheehan for their timely comments and suggestions on earlier drafts of this article.

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Note

1. This research has IRB approval and is part of an ongoing project on the impact of COVID-19 on health-care providers and their families. All names are pseudonyms.

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