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The Roles and Purposes of Caring Touch in Health Professional Practice: A Discourse Analysis

Nicola Power  | Joanna Fadyl | Simon Walters | Deborah Payne

Auckland University of Technology, Northcote, Auckland, New Zealand

Correspondence: Nicola Power (nicola.power@aut.ac.nz)

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ABSTRACT

Research literature concludes that caring touch contributes to physical and psychological wellness. However, in health practice, touch is constructed as acceptable in some situations and not in others. Utilising interviews with nurses and other health professionals, the aim of this study was to explore the discourses shaping the role and purpose of caring touch in health practice. Poststructural methodology, drawn from the work of Michele Foucault, was employed to make visible what discourses of caring touch were legitimised or marginalised in a health setting. At times, caring touch was constructed as an expression of humanness, whilst at others it was expressly part of a professional practice. Findings showed that discourses shaping choices to engage in acts of caring touch with patients were linked to the social construction of the relationship between the patient and the professional. Whilst some practitioners talked about integrating caring touch into practice with little difficulty, for others, caring touch was constructed as an 'extra'. Discourses that shaped professional subjectivities were key to those differences. Findings from this paper build on existing understandings of caring touch in literature by highlighting the unique interplay of discourses in practice.

1 | Introduction

Acts of caring touch are multifaceted and contextual. Shaped by historical, social and cultural discourses, they appear to be inextricably related to values and attitudes within a community or culture. Within socio-cultural discourses, touching is a complex, dynamic subject, often reflecting deeper tensions around power, gender, culture and identity, at times making the act of one human touching another problematic (Cascio et al. 2019; Gliga et al. 2019; Wood 2015). In some societies, touch is seen as an essential expression of intimacy, support and solidarity (Schirmer et al. 2022), while in others, it may be viewed as invasive or inappropriate, especially in public or formal settings (Saarinen et al. 2021). The increasing awareness of consent and personal space has further complicated the practice of touch, although Saarinen et al. (2021) suggested that the acceptance of touch is modified by contextual psychosocial factors such as the toucher's facial expressions, stage of

relationship and situational factors such as a person's distress or pain.

A substantial body of research highlights the benefits made possible when humans have opportunities to receive caring touch throughout their lifespan (Airosa et al. 2013; Kearney 2021; Lecat et al. 2020; Shamay-Tsoory and Eisenberger 2021). It follows therefore that acts of caring touch may be useful when a person is in the care of a health professional (Di Lernia et al. 2020; Liljencrantz et al. 2017). Moreover, within the research literature, the understanding of caring touch as complementary to good health and well-being is so dominant, there seems little to contest its benefits.

Similar to Airosa et al. (2013) and Ozolins et al. (2015), in this study, we defined caring touch as a non-verbal communication, an effective way to convey care, comfort, reassurance, consolation or praise. Takeuchi et al. (2010) proposed that caring touch can be defined as 'putting hands on someone in order to

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show them kindness and affection' (p. 110), suggesting that touch is enacted to demonstrate care, not simply an action. Rather, it is a form of non-verbal communication that may promote well-being in interpersonal relationships. However, in Western societies, where there is a climate of suspicion often linked with acts of touch, particularly touch between people who do not have a close relationship (Cascio et al. 2019; Kelly et al. 2020). Unspoken rules about where and when a person is able to touch another prevail throughout daily life rendering the act of touching another person complicated (Gliga et al. 2019). For health professionals, where the need to regularly touch others converges with relationship conventions related to culture and gender (Kelly et al. 2018), they are required to negotiate these complex discursive constructions on a daily basis.

A number of studies have highlighted the potential physiological and psychological benefits of caring touch to (a) benefit those in hospital recovery (Airosa et al. 2013; Bush 2001; Chang 2001; Currin and Meister 2008; Henricson et al. 2006; Routasalo 1999); (b) positively affect the physical and mental development of babies and children (Bellieni et al. 2007; Field 2014); (c) assist people in pain (Airosa et al. 2013; Currin and Meister 2008; Estabrooks and Morse 1992; Field 2010; Smith et al. 2002); (d) provide a way of conveying respect and positive feelings that specifically comfort those nearing the end of their life (Chang 2001; Kearney 2021), and (e) reducing stress in the hospital and clinical environment (Davin et al. 2019; Elkiss and Jerome 2012; Lecat et al. 2020; Papatthanassoglou and Mpouzika 2012).

There is also a strong body of evidence that concludes being devoid of caring touch across the lifespan is problematic, particularly in terms of diminishing psychological well-being, increasing the potential for anxiety, insecurity and aggression (Davis et al. 2017; Nelson 2007; Ratcliffe 2012). The empathetic, caring touch of a health practitioner occupies a complex position within contemporary healthcare. Caring touch is congruent with the foundational values of many health professions, which emphasise compassionate, person-centred care and emotional presence (Medical Council of New Zealand n.d.; Nursing Council of New Zealand n.d.; Nursing and Midwifery Board of Australia n.d.; Paramedic Council of New Zealand n.d.). However, the practice of caring touch simultaneously may encounter institutional barriers particularly by those shaped by biomedical practices which often prioritise efficiency, task completion and quantifiable outcomes over relational forms of care (Babaei and Taleghani 2019). Protocols regarding physical contact including issues of consent, patient safety and the prevention of inappropriate behaviour, shape how, when and by whom touch is deemed acceptable. Such regulations are further reinforced through surveillance practices. Professional education and codes of conduct further discipline touch, framing it as a skill to be deployed judiciously within defined contexts. Arguably, this reflects a broader tension between affective dimensions of care such as touch, and institutional models of practice. Within the health professions explored in this study, each is shaped by distinct discourses, norms and regulatory frameworks. In nursing, caring touch is central to professional identity through longstanding discourses of compassion, relational presence and holistic care, yet task-oriented workloads produce tensions that may constrain how such touch is enacted (Smith et al. 2024). In medicine, touch is primarily framed by

biomedical authority and clinical objectivity; it is legitimated as diagnostic or procedural and tightly governed by professionalism and risk management, which often renders explicitly comforting touch as secondary (Buono et al. 2025). This mirrors in some way its integration in paramedicine, where touch is organised around urgency, stabilisation and safety in unpredictable environments, privileging procedurally justified contact while arguably making subtle gestures of reassurance discursively marginal or invisible (O'Toole 2023). Throughout midwifery practice, touch is integral to relational continuity and support for physiological birth, legitimised as both clinical skill and affirming presence within partnership models of care, although is increasingly regulated by medico-legal and institutional protocols (Zulala and Rohmah 2023). These various configurations of caring touch in health practice illustrate how it is not merely a technique but a governed practice whose meanings and possibilities are produced and limited by professional discourses, organisational priorities and ethical surveillance.

The undoubted complexity of human touch and the potential for harm and misinterpretation often conflicts with the understandings of how it can be of great benefit. It is the multiplicity of meaning and potential of caring touch to affect humans in so many ways that makes it complicated. Given its capacity to benefit those undergoing healthcare, but also its potential to become problematic, it is a topic worthy of deeper understanding particularly in the working lives of health professionals for whom this is a fundamental dynamic in everyday practice. The research question therefore asked what discourses of caring touch are in play in the working lives of a health professional? The aim was to investigate these discourses and explore how they are legitimated or marginalised in health practice.

2 | Study Design

The focus of this study is on the discursive constructions of caring touch in health practice as articulated by individual health professionals. An important aspect of the study was to explore whether meanings differed not only across health practices but also within each profession. This has not been studied to date and therefore adds valuable insight into what supports or marginalises this act of care, having the potential to add to current understanding for nurses and other health professionals. The work reported here comes from a larger doctoral study investigating discourses of caring touch in health professional practice.

2.1 | Methodological Considerations

When analysing how health practitioners make decisions about the use of caring touch in their professional practice, it is important to note that all people are constituted by discourse (Foucault 1981). The discourses we participate in are multiple and never fixed, and as such, we have the potential to be constituted in different ways. Therefore, there is a flexibility and openness to the varying ways people will talk about caring touch. Consequently, the complexity of touch, specifically caring touch, required an epistemological approach that would

account for diverse constructions and the possibility of multiple subjectivities. It was important to be able to recognise how different subject positions were produced by the health professionals in this study and how these played out in the context of caring touch in practice. The approach was one that could acknowledge multiple perspectives and explore the way power operated to open up or close down certain ways of thinking or being at particular times. Furthermore, the complexity of understanding how touch is understood by health professionals required a methodology that recognised the presence of multiple values, viewpoints, practices and acknowledged that meanings are unstable and open to interpretation (Cheek 2000). Thus, we used a Foucauldian poststructuralist approach to explore what was taken for granted and how nurses and other health professionals conceptualised caring touch in their practice. Poststructuralism offers a distinctive way of analysing the production of knowledge and attempts to explore and analyse how ‘truth’ may be played out (Crilley and Chatterje-Dooddy 2019). Additionally, it invites questions that reach beyond the general common sense understandings of the world in which humans live (Gavey 2011).

3 | Methods

Following ethics approval and advertisements in professional journals, the participant information sheet explained the aims and purpose of the study. Interested parties contacted the first author by email for further details. All participants were advised of the voluntary nature of participation and the right to withdraw from the study at any time. Written informed consent was obtained from all participants.

3.1 | Participants

The uniqueness of this study meant the participants in this study were a starting point to exploring the topic, and as such, participants were accepted on a first come basis providing they met the selection criteria of 10 or more years’ experience in a clinical setting (including as a trainee). This was the only inclusion criterion (Table 1). This criterion was specified to obtain the rich data that included the nuance and complexity

gained from a range of experiences over a period of time. Age, gender and ethnicity were not exclusive. Although set within Aotearoa New Zealand, this study did not focus on a Māori perspective specifically. The Māori worldview, which emphasises relationality and interconnectedness among individuals and communities, is a vital component of health practice in Aotearoa New Zealand but was not the focus of this study. Purposive and snowball sampling were the main recruitment tools used to gather participants from the specific groups. All participants worked in the Auckland region, where the data collection occurred at a place chosen by the participants. In all cases, this was at their place of work.

3.2 | Data Collection

Semi-structured interviews were employed as they can provide a useful way of uncovering how people construct meaning pertinent to a specific topic and facilitate autonomy to explore ideas enabling the flow of conversation on a complex topic of enquiry (Adeoye-Olatunde and Olenik 2021; Karatsareas 2022). Interviewing in this way sought to offer up the opportunity for participants, who positioned themselves within complex, often subjugated discourses, to articulate aspects of their perspectives of caring touch in a health practice setting.

Following initial opening questions, a broad question such as, ‘can you talk to me about touch in your daily practice’, encouraged and invited the participant to share their thoughts and experiences. Questions were asked specifically about caring touch, such as:

- How did you learn to use touch in your professional capacity?
- Tell me about using caring touch in your practice today (in what situation, how, when and with whom?)
- What factors (if any) influence your decision to touch?

The first author conducted all the interviews making notes throughout each interview to document any inflections in the voice and body language that might be important to the statements made. Statements as related to this study reflect Foucault’s concept whereby a statement describes the most basic

TABLE 1 | Results of participant recruitment.

Health profession	Ethnicity	Identified gender	Area of practice	Range of years of experience
Nurse	4× NZ European 1× Filipino	<i>n</i> = 4 female <i>n</i> = 1 male	4× General hospital 1× Accident and medical	10–21 years
Paramedic	5× NZ European	<i>n</i> = 2 female <i>n</i> = 3 male	5× General hospital	11–17 years
Midwife	5× NZ European	<i>n</i> = 5 female	1× Homebirth 1× Hospital based 3× Independent (home and hospital)	10–23 years
Doctor	4× NZ European 2× Chinese	<i>n</i> = 3 female <i>n</i> = 3 male	2× General practitioner 3× General hospital 1× Accident and emergency	5–21 years

Note: Midwives in Aotearoa New Zealand are trained specifically in this health practice via direct entry into a 4-year bachelor’s degree. They do not, by rule, have a nursing background. This differs internationally.

element of discourse and may comprise other than written or spoken text. Foucault described a statement as 'basic' because any interpretation of the statement relies on understanding the relationship and context in which they are made. Foucault suggested 'a statement belongs to a discursive formation as a sentence belongs to a text' (Foucault 1969/2002, 130). A statement therefore can be seen as the most elementary component of a discourse and provides a logical point to commence analysis (Fadyl et al. 2012). Each interview was transcribed verbatim, and a pseudonym allocated to each participant to protect identity.

Notes were also made regarding statements that pointed towards a possible discursive construct. For example, several participants stated that acts of caring touch were a part of being a nurse that was unquestioned. Documenting biases and assumptions made about the interview process through notetaking was also important in maintaining rigour during later analysis.

3.3 | Data Analysis

The first author led data analysis, with regular input from the other authors through analytic presentations and conversations. Transcripts were read and re-read to establish a deep connection with the data, which enabled us to map statements and their relationships to identify patterns and therefore discourses. A discourse became noticeable when communicated knowledge within a group of statements made it possible to say something was being understood as 'true'.

The aim of our analysis was to analyse the patterns and relationships between the statements and the objects they constructed (Foucault 1969/2002). When Foucault spoke of the object, he described it as being formed through relationships established 'between institutions, economic and social processes, behavioural patterns, systems of norm, techniques, types of classifications, modes of characterization' (Foucault 1969/2002, 49). However, this article focuses explicitly on the constructions of these participants where caring touch was the key object of knowledge analysed. Engaging with a Foucauldian discourse analysis presents methodological challenges, given Foucault's own resistance to prescribing a fixed analytical approach (Cheek and Porter 1997). As Foucault (1978/2000) stated, 'I take care not to dictate how things should be' (p. 288), instead encouraging scholars to treat his work as a 'toolbox' from which to select an appropriate approach to their specific research contexts (Hope 2015). In the absence of a definitive methodological blueprint, our analysis was guided by the structured approach proposed by Kendall and Wickham (2003) who outlined five steps to navigate the analytical process of discourse: (1) identifying discourse as a system of systematically organised statements; (2) the identification of rules and the production of statements; (3) the identification of rules that limit the sayable; (4) identifying the conditions that enable the emergence of new statements, and (5) acknowledging the interplay between discursive and material practices. While these steps provided a useful scaffold, particularly in the initial stages of analysis, the flexibility inherent in Foucault's conceptual 'toolbox' enabled us to formulate bespoke

analytical questions that were more closely aligned with the specific aims and context of this study.

4 | Findings

Our findings indicated various discursive constructions regarding the roles and purposes of caring touch. Here we discuss this in terms of three distinct constructs and their relationships and dynamics: (a) the role of caring touch as comforting, (b) the interplay between caring touch, the fostering of relationships and available time, and (c) caring touch to gain compliance and act as a distraction. NB: Participants have been allocated a pseudonym to protect anonymity.

4.1 | The Role of Caring Touch as Comforting

Participants most often understood acts of caring touch as a resource to comfort a patient in pain or distress, and to encourage a safe environment. There were many instances when a health practitioner felt 'encouraged' to provide caring touch, not necessarily as a practitioner but as a human showing empathy and care to another human in an environment where they needed support.

There are other occasions where the patient might be quite distressed or crying or whatever. You know? Sometimes I'll give them a hug or sometimes I'll touch them on the knee, something like that. 'Are you okay? Do you want to keep going or do you want to stop?' And I've had many occasions where patients just reach out and just give me a hug at the end of the consult.

(Sue—GP)

Sue often works in an environment where she sees the patient alone and perhaps over a number of years and was comfortable incorporating caring touch into her practice when necessary. She employed a variety of caring touch and was accepting of being the recipient of caring touch. In this excerpt, caring touch was deployed as a means to demonstrate compassion and was employed as part of a professional remit; a resource to be called upon at an appropriate time.

Although practitioners across disciplines draw on elements of professional discourse, the ways in which this discourse is constructed and the subject positions made available are not uniform. Rather than being shaped by dominant iterations of professional discourse that can position doctors as refraining from caring touch, Sue normalises such touch as an appropriate dimension of her professional role and as a means of expressing empathy. As with other participants in this study, it remains difficult to ascertain whether the incorporation of caring touch into her practice emerges primarily from the influence of a humanistic discourse or whether it reflects her personalised reworking of professional discourse not widely shared among her peers.

Within the general practice context, the doctor–patient relationship is one in which the doctor typically occupies the primary caring role and is often the patient's sole point of professional contact during a consultation. This relational

configuration arguably affords greater opportunities for establishing a sense of safety, within which caring touch can be enacted without the constraints or concerns reported by other practitioners

Lois, a nurse, discussed another way to use caring touch to bring comfort to a patient.

I feel for them when they come to us. I know some can be unpleasant but some of that comes from fear of where they are and cause they're in pain. Many of them look really vulnerable so I guess it's part of my job to care for them, so they feel safe. So, if a touch on the arm or the shoulder can help then I think it's a good thing to do.

The notion of caring touch as helping to create an environment that was deemed safe suggests a particular meaning of both the patient and the health practitioner. By constructing the patient as vulnerable, Lois considers an approach in which she may be able to assist the patient additional to assessment, diagnosis and treatment. She considers her role as a caring nurse, one who is required to manage the multiple needs of the patient, physically but also emotionally, and engaged in caring touch to encourage the patient to feel safe. Lois draws upon, and reproduces, traditional discursive constructions of nursing in which caring is positioned as central to the profession's identity (Morse et al. 1990; Yam and Rossiter 2000), despite more recent scholarship suggesting that care has become less prominent within contemporary nursing practice (Smith et al. 2024). Within this discursive landscape, where societal expectations of caring intersect with longstanding professional narratives, acts of caring touch performed by nurses may continue to be legitimised, anticipated and largely unquestioned by patients. This historically embedded conceptualisation arguably affords nurses a particular licence to touch; one not necessarily available to other health practitioners whose roles are not symbolically anchored in notions of caring. Notably, Lois does not acknowledge the potential implications for her male colleagues, nor does she consider the gendered dynamics that may shape how caring touch is introduced, interpreted or experienced within clinical encounters.

4.2 | The Interplay Between Caring Touch, the Fostering of Relationships and Available Time

4.2.1 | Caring Touch to Foster Relationships

Across the health disciplines, the ability to develop relationships with patients is diverse (Feo et al. 2017; Morgan 2008). The participants in this study contrasted considerably regarding opportunities available to them to develop such relationships. The opportunity to develop a relationship with patients offered an increased opportunity to engage in acts of caring touch, and the function and place of caring touch within relationships was variable.

For some participants, acts of caring touch occurred spontaneously, without considered thought, as an innate part of their practice. Often describing themselves as 'touchy feely', these practitioners consider acts of caring touch as an asset, a resource they brought to practice that produced benefits to the wider care they were able to provide.

I decided after a few years to follow my natural instinct and just use it [caring touch] as part of me as a doctor, my practice. I've come to realise that using it [caring touch] with a patient allows you to connect with them more. I learn to 'read' them better by having a better relationship ... what do I mean by that, umm, maybe how they are feeling. I think I'm better doctor for it.

(Tom—doctor)

When a health practitioner conceptualises caring touch as a critical resource that facilitates the development of positive therapeutic relationships, it can create opportunities to 'know' the patient in ways that may not otherwise be accessible. Constructing caring touch in this manner suggests an enhanced capacity to interpret patient cues, which may in turn contribute to other dimensions of practice, including assessment and diagnosis. Similar to Sue, previously, Tom positioned himself within this understanding, drawing on what he described as a 'natural instinct' to more effectively assess his patients' needs. Although Tom felt confident that his approach to incorporating caring touch was beneficial for both himself and the patient, he appeared unaware of the complex and variable ways in which touch may be experienced by individuals. His practice was guided primarily by his personal way of engaging with patients, rather than by consideration of the potential implications for unfamiliar patients or the recommendations articulated within professional guidelines.

Lyn, a nurse, echoed Tom's suggestion that embedding caring touch into practice holds the potential to benefit a patient.

I wonder sometimes if someone will pull me up on it [using caring touch], but it's me, part of me, part of how I show care, and patients seem to respond well to it. They seem to be more open to talking about how they are feeling.

(Lyn—nurse)

Despite a concern that she may be chastised for her actions, Lyn's open acts of caring touch feature as part of her practice. Like Tom, this nurse suggested acts of caring touch encouraged valuable communication with the patient, which may offer opportunities to assist the patient in a broader capacity, such as articulating uncertainties about treatment. Although most participants drew on constructs of professionalism and biomedicine to describe their care for patients, Tom and Lyn engaged in acts of caring touch to provide additional patient care. This created an intersection of multiple aspects of care where they were able to practice in a way that they described as fostering their professional relationship with the patient.

4.2.2 | Relationships Enabling Acts of Caring Touch

Several participants suggested that building a relationship in the first instance was important for enabling caring touch. Once the relationship between patient and health practitioner had been established, the integration of caring touch was conceptualised as more acceptable. Sharon and Fiona, both hospital-based nurses, suggested this approach facilitated their use of caring touch.

Although I tend to use caring touch as part of me being a nurse, I think I do this more when the patient is with us for a while.

(Sharon)

It does make it [caring touch] easier when we know them. You know? We know they know us and seem really happy to get that more friendly approach.

(Fiona)

Sharon and Fiona suggested that when nursing practice facilitated the opportunity to spend more time with the patient, there were further possibilities to develop a positive relationship where acts, of caring touch, could be introduced. This notion links to the previous suggestion by Lyn implying caring touch assisted patients to feel safe. When a patient is an unknown, it may preclude caring touch. Likewise, when a practitioner is unknown to the patient, it may indicate a resistance to accepting acts of caring touch. In Sharon's quote, time in the presence of the other is constructed as a medium for enabling caring touch. The discourse of time as a prerequisite for cultivating the patient relationship functioned as a discursive tool through which nurses sought reassurance that caring touch would be interpreted appropriately. In this framing, caring touch was not initiated primarily as an expression of the nurse's individual character or personal inclination. Instead, these nurses constructed time as a legitimising mechanism; an important guide for determining when and how caring touch could be ethically and professionally integrated into practice.

4.2.3 | Caring Touch as Time Consuming

Another way in which participants invoked time related to its availability as a determining factor in whether caring touch was incorporated into patient care. In these accounts, limited time functioned as a practical and organisational constraint that shaped decision-making around the use of touch. This aligns with previous research demonstrating that health professionals frequently report concerns about insufficient time to engage meaningfully with patients, which in turn affects the relational dimensions of care. This was particularly so for doctors and nurses in hospitals and clinical environments (Gerada et al. 2018; Westbrook et al. 2011).

In this study, while there were several statements where a constraint on time was drawn upon as a rationale to not incorporate caring touch into practice, these differed between disciplines and contexts.

Maybe we don't do it enough? I don't know... Sometimes we are in too much of a hurry. We have too many patients and although I'm attentive to everything the patient tells me, I may not go the extra mile if you know what I mean.

(Lucy—hospital doctor)

I think one of the biggest drawbacks is we [the doctors] give ourselves 15 minutes or less to solve the problem and it's actually not enough time to do it, so there certainly

isn't the time to think about holding a hand or giving a hug.

(Mike—hospital doctor)

Lucy and Mike acknowledged that whilst caring touch may be a useful addendum to patient care, it was not a priority. They both stated that the ability to engage in caring touch was constrained by the time they were able to spend with the patient. Of interest is the fleeting suggestion made by both Lucy and Mike that providing caring touch was an “extra”; an additional aspect of care only given if time permitted. This contrasts to the earlier statements made by other participants who suggested the integration of caring touch into practice was not dependant on ‘extra’ time; rather, it was an act that could be included whilst performing more clinical aspects of care. The suggestions by these health practitioners support the notion that contemporary biomedical discourses persist as a structuring force in contemporary healthcare, shaping clinical priorities in ways that marginalise non-clinical forms of care (Mazzota 2016; Umberger and Wilson 2024).

Although Tony concurred that time was often limited, his way of managing practice to enable caring touch contrasted with those quoted above.

We don't get a lot of time with the patient, but I think whatever time we do have means we need to accomplish a whole lot. As much as many of the young paramedics would assume getting leads on and checking stats is first up, actually just taking a few moments, seconds actually, to touch a patient on the arm or shoulder and let them know you are going to take care of them is just as important – for me anyway. Maybe that's experience talking, but I can imagine people think they don't have the time for hand holding when really a few seconds is all it takes, and it can make a difference.

(Tony—paramedic)

Tony expressed the notion that even the briefest act of caring touch to reassure a patient was a worthy use of limited time. The brevity of this act was considered important enough to enact prior to commencing with more clinical care. Similar to other paramedics, being able to transition between acts of caring touch and the technical skills needed to assist the patient was part of practice. Although Tony alluded that it was his lengthy experience that granted him the understanding of when to integrate caring touch into his practice, all of the health practitioners in this study had extensive experience, yet not all practised similarly, indicating experience was not necessarily an enabler of caring touch. For Tony, the medical discourse and humanistic caring discourse co-exist in health practice. Whilst for some health practitioners, their dual presence may cause confusion, Tony and others, may not be professionally constrained by one or the other. I refer to this as a ‘discursive dance’ whereby they make decisions using their professional judgement, influenced by the discourses in play at that specific time in that specific place. Arguably, therefore, it is the discourses prevailing in a particular context that may produce health practitioners who take up subject positions that enable or constrain acts of caring touch.

As a nurse in an emergency department, Lyn suggested colleagues often used lack of time as an excuse as to why caring touch could not be actioned.

I hear colleagues say, 'we don't have time to for all the nicey nicey things like holding a hand or hugging', and it makes me really mad. I mean, it's just a friggin excuse. They either don't want to do it or don't think about doing it. I mean how long does it take? Seriously, what's wrong with them? A hand on the shoulder as a patient leaves, or a pat on the leg as they're standing up from a consultation. Even the odd touch on an arm when they are looking anxious. It's crap. If they want to be caring in their practice, they do have time. They're making excuses.

(Lyn—nurse)

Similar to Tony, Lyn described the relative ease with which caring touch could be incorporated into treatments or appointments without significantly affecting the time required to complete other clinical tasks. She positioned resistance to caring touch not as a consequence of time pressure but as a matter of practitioner choice, implying that decisions about touch are shaped more by personal orientations than by organisational constraints. This framing suggests that references to time limitations may operate as a discursive strategy to reinforce a particular construction of caring touch as supplementary an 'extra' or a 'nice to have' rather than an integral component of practice. Notably, Lyn did not acknowledge that her colleagues may be influenced by alternative discourses in which caring touch is problematised or viewed negatively. Her frustration therefore obscures other potential explanations for their reluctance where colleagues may be responding to discourses that construct caring touch as professionally risky, unprofessional or sexualised. These discourses are identified in the larger study and beyond the scope of this paper.

4.3 | Caring Touch to Gain Compliance and Act as a Distraction

4.3.1 | Caring Touch to Gain Compliance

A further concept of caring touch was articulated when a health practitioner endeavours to put a patient at ease and reduce their discomfort through caring touch. The practitioner, knowingly or otherwise, could also be gaining patient compliance that facilitates treatment.

I think being able to care for them [the patient] with using caring touch means they seem to trust what you are saying or what you need to do.

(Fiona—nurse)

In my experience they relate to what you're saying much better when you're holding their hand or got an arm around their shoulder. It also makes it easier to get other things done, like getting a line in.

(Jo—paramedic)

The statement that 'caring touch means they seem to "trust"', constructs it as being of value to a much broader context of caring for a patient. Once trust is established, it suggests the notion of the patient feeling safe is present, and arguably this produces patients who are more accepting of examination and treatment as suggested by Robert.

Some [patients] resist [treatment] and the pain they were okay with in the ambulance seems worse. Others might feel some relief as they know they can get help, and they seem to just give themselves up to whatever the team want. I know when I place a hand on the shoulder or the arm it helps... I know it does.

(Robert—paramedic)

Robert assists a diverse number of patients, where some acquiesce, and others do not. He suggests that at times, caring touch is a tactic to create an environment whereby a patient is willing to capitulate, implying that docility was a necessary precondition to ensure the treatment was able to be provided. Furthermore, there is an additional effect of the 'hand on the shoulder' articulated in this statement in helping to alleviate some of the pain experienced, which again may contribute to a compliant patient.

These practitioners draw on a discursive construction of the caring health professional; one who employs caring touch as a productive technique intended to support the patient's recovery. What is notably absent from their accounts, however, is any recognition that such acts of caring touch may also be interpreted as a potentially manipulative exercise of power, functioning to shape or regulate the behaviour of patients who are perceived as non-compliant. In this sense, their statements reflect a unidimensional framing of caring touch as benevolent, overlooking the possibility that touch can simultaneously operate as a subtle modality of influence within the clinical encounter.

4.3.2 | Caring Touch as a Distraction

The diversity of caring touch discourses is also evident when employing caring touch to assist in the relief of pain (Mancini et al. 2014). This was apparent throughout our analysis, where its function as pain relief was commonplace.

When a woman is in pain from labour, I know that by giving her back a rub, or foot rub for that matter, that it will, to some degree, take her mind off focusing on the pain. People think it's just because touching is what we do but there's good evidence to say that it really does work as a distraction. It's all about the route that the nerve message travels.

(Jen—midwife)

Jen's statement draws on scientific evidence to support her use of caring touch. She raised the physiological concept of the gate theory of pain (Campbell et al. 2020), whereby it is possible to subdue feelings of pain by introducing an alternative sensation for the brain to focus on. This suggests that although many midwives subscribe to the discourse of natural birth, it does not preclude biomechanical regimes of

understanding. They are not mutually exclusive. When Jen drew on the physiological disruption that caring touch can offer in reducing signals of pain, she demonstrates that health practitioners have the ability to draw on multiple discourses to determine what actions are doable and thinkable to enable practice.

Others talked about caring touch as particularly useful when attempting a medical procedure that may produce discomfort.

I know that when I have an anxious patient and I have to get a line in, if there is another colleague at hand, and usually there is at this point, I get them to stroke the forearm of the arm I'm not working on to distract them [the patient]. It's something we do on kids, but it works well on anyone that needs a sort of diversion (laughs). Works a treat.

(Robert—paramedic)

Despite some participants talking about being hesitant in their use of caring touch, its ability to distract is well documented in the scientific literature (López-Solà et al. 2019; Nursanti et al. 2020; Sparks 2001). In his interview, Robert constructed this distraction technique as a resource to benefit both the patient, in terms of their pain relief, and himself, in terms of ensuring he is enabled to provide good care. This awareness of caring touch as simultaneously aiding distraction and care demonstrates the multiplicity of caring touch and illustrates that various enactments of caring touch can occur synchronistically.

5 | Merging Different Types of Touch

Using caring touch as a resource to divert patients' attention connects closely with the descriptions from some participants who discussed caring touch in a way that does not position it as a stand-alone act. They spoke of their integration of caring touch with acts of procedural touch. Tony articulated how he employed a strategy whereby he was able to integrate both types of touch within his practice.

I will go in and sit down and just holding someone's hand also gives you the chance to assess skin tone... that's part of the reassurance and it comes with experience.

(Tony—paramedic)

Tony submits his level of experience as a paramedic as enabling him to comfortably use caring touch and at the same time perform the procedures his practice required of him to assess the patient. Caring touch in this context was constructed as an act that could be integrated into practice with apparently little effort.

In these examples, the discourses that construct procedural touch and caring touch do not fight for dominance; rather, they may be enacted alone or simultaneously. There is no suggestion that caring touch is only possible in certain situations, and they are able to enact caring touch without too much deliberation.

6 | Discussion

Kelly et al. (2018) suggest research on touch in health professions is conflicted and describes it as an 'ill-defined practice in which wider societal rules operate' (p. 208). The findings from this study add to this understanding by making exploration of the discourses of caring touch in health practice an important addition to current insights.

Foucault argued that we should never assume we have reached a point where we have discovered the final truth about a topic of interest (Mills 2003). By doing so, we limit the development of knowledge. Hence, when varied but significant accounts of a topic are selected and brought together, they have the opportunity to conspire and produce insights of knowledge and potential 'truth' (Garratt et al. 2013). Echoing Foucault's (1972/1980) notion that multiple realities and truths exist in one given situation, we therefore did not seek to find the 'truth' pertaining to acts of caring touch; rather, we sought to explore the ways in which caring touch was discursively constructed. Discourses produce various possibilities of 'truth'. Suggesting otherwise limits the development of further knowledge (Foucault 1972/1980).

Caring touch has long been discussed as central to nursing practice (Arslan and Ozer 2016; Kelly et al. 2018; Pedrazza et al. 2018). Whilst much of the current understandings come from models of nursing, our study included participants across multiple health professions, including nursing. This study showed that for some participants, caring touch was proposed as fundamental to caring; however, for others, it was a possible adjunct to other aspects of caring, which took priority. Multiple constructions around the importance and purposes of caring touch were identified. This study suggests that the use of caring touch and its complexities are not clearly defined by disciplinary boundaries. The experiences and challenges are common across professions. What this study showed is that where participants experienced competing constructs of caring touch, it produced health practitioners who articulated significant concerns about their professional boundaries and the act of caring touch. Consequently, there were contrasting statements and contradictions throughout the data that presented caring touch as vital in some situations and unnecessary in others, at times resulting in practices of caring touch that were concealed or marginalised.

Whilst caring touch was constructed by some participants as an act employed to form relationships with patients, conversely, it was constructed by others as difficult to employ until a relationship with a patient had been established. This supports the findings by Molina-Mula and Gallo-Estrada (2020), who suggest that forming a positive relationship with a patient develops trust that improves the experience and enhances healing. Similarly, Karlsson and Pennbrant (2020) suggest there is a 'prerequisite for touch' (p. 3) whereby it is important to create suitable conditions to facilitate a rapport where trust is established. Once this has been established, the patient may be more receptive to caring touch and the practitioner more comfortable in initiating the act. In this study, the relationship formed between the health practitioner and patient was significant in producing possibilities of caring touch.

For many participants, the opportunity to develop these positive relationships with patients was dependent on the availability of time. This has been a topic of concern in practice and notable in

numerous research studies (Glantz et al. 2019; Karlsson and Pennbrant 2020; Molina-Mula and Gallo-Estrada 2020; Sauerbrei et al. 2023). Glantz et al. (2019) and Sauerbrei et al. (2023) expressed concern that the limited time nurses and doctors are able to spend with a patient in the hospital setting results in difficulties establishing relationships, thereby arguably reducing the potential for instigating acts of caring touch and the possibilities for well-being.

Embedding caring touch into practice for some participants was complementary to other tasks and integrated with little difficulty. Others, however, propose caring touch as a time-consuming 'extra' that restricted time for other important tasks. Some participants suggested an approach whereby types of touch interactions occurred simultaneously, ensuring both the physical and emotional needs of patient care were met. Accordingly, there existed possibilities for an interplay of discourses, demonstrating that discourses of caring touch do not necessarily compete with other discourses of care in practice.

This study showed that some participants were engaging in acts of caring touch to distract the patient from discomfort and possibly gain compliance for treatment. Using caring touch to distract from an uncomfortable procedure or as an aid to limit pain has elicited much research, showing significant evidence to support its effectiveness across age and gender (see e.g., Bascour-Sandoval et al. 2019; Karafotias et al. 2017; Mancini et al. 2014; McGlone et al. 2014). Although some health practitioners enacted caring touch for this purpose, others did not discuss this. This may be related to differences in training and experience. Nevertheless, if acts of caring touch hold the possibilities to assist with relieving discomfort, it suggests the full potential of caring touch has yet to be realised in health practice.

6.1 | Limitations

Discourse analysis is an interactive process that is strongly linked to the maintenance of power. Through this power, there is the potential to privilege certain perspectives and silence others (Foucault 1981; Kendall and Wickham 2003). This is echoed in this study, where exploration of the ways in which health practitioners constructed caring touch had the potential to limit understandings. As such, there lies the potential for other discourses to be overlooked or neglected.

A relatively small number of health practitioners' took part in this study. However, this qualitative study was interested in exploring what these specific people had to say and what discursive practices were guiding their integration or not of caring touch. Certainly, a larger participant group across a number of geographical locations could have offered further insight.

The privileged voices of female were dominant in this study. Further research is needed to explore, for example, the male nurse perspective and the possibilities of other discourses. Additionally, the patient perspective was absent from this study as the focus was on the lesser understood discursive practices of health practitioners engaging in caring touch. Examining the patient perspective would also add valuable understanding of this complex form of communication.

The analysis of the data in this study leaves unanswered questions regarding how the broader discourse of caring touch is policed and maintained.

7 | Conclusion and Implications for Practice

Findings from this study seek to contribute to an increasing body of knowledge exploring multiple constructions and acts of caring touch in nursing practice. Exploring this complex topic using a Foucauldian approach underpinned by post-structuralism enabled the identification of discursive themes that are woven throughout our findings and the ability to challenge taken-for-granted truths about caring touch (Foucault 2005; Peters 2003).

As a discourse-centred study, the data provided by the participants were not privileged as objective and indicative of truth, rather as local and contextual. The deconstruction of statements opens up a range of understandings, all of which offer potential for change. An important finding of this study showed that health practitioners continue to be challenged by diverse dominant discourses pertaining to caring touch that are embedded in their practice. Whilst some participants integrated acts of caring touch into practice with little challenge, there were occasions when the tensions articulated by others made caring touch in practice problematic.

It is perhaps the understandable inability to understand the reciprocal subtleties of touch that produce contrasting interpretations of this complex topic. Wearn et al. (2020) stated, 'It is what we learn in the process of using and reflecting on touch that transforms us' (p. 752), suggesting that the reciprocal and indeterminate nature of caring touch is something both difficult to research and to define. However, underpinning acts of caring touch is a discourse that constructs humans as having the capacity to empathise and have compassion for one another. We argue that for some, it is this discourse that can motivate nurses and other health practitioners to engage in caring touch with patients, even when their personal inclination is not to do so.

Unpacking the complexity of caring touch practices at a tertiary education level may illuminate more nuanced understandings enabling the multiple meanings of human touch to be more widely acknowledged and disseminated during the training of nurses and other health practitioners. If explicit discussions relating the caring touch and the possible tensions and contradictions surrounding this form of communication were able to be articulated in a safe educational setting, it may provide one way for all health practitioners to open up critical engagement and change future possibilities.

The act of touching another is without doubt an act that can produce disparate subject positions and carries with it a deep and complex meaning. This study adds to the complex understandings that nurses face when engaging in acts of touch, but we argue that giving consideration to, and reflecting on, non-verbal methods of communication such as caring touch is an aspect of nursing care that may be marginalised in both training and practice. When a topic is not integrated into the undergraduate education of nurses, it marginalises its significance. Consequently, creating curricula for a postgraduate programme or other professional development modules where nurses and other health professionals have the opportunity to consider the complexities of caring touch and examine the discourses in circulation might implicitly affect their practice.

At a time where health practitioners across the globe face ongoing challenges of health systems buckling under the constant pressure of rising chronic conditions, mental health crises

and budgetary constraints, now is the time to think more broadly about ways to enhance well-being that have been relatively overlooked or marginalised as an aspect of care. Our findings are a significant contribution to understandings pertaining to caring touch in health practice. We hope to stimulate further exploration of the complexities implicit in caring touch as it has important implications for the education of nurses, their professional practice and future health research.

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Ethics Statement

Ethical approval for this study was obtained from the Auckland University of Technology Ethics Committee (AUTC: ref number 15/119).

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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