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Doctors should not shake the hands of patients

INVITERT KOMMENTAR

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It was common practice for doctors to greet patients with a handshake until March 2020, when Norway was hit by the COVID-19 pandemic. There are still good reasons to avoid handshaking in healthcare settings.

Art and literature dating back several thousand years illustrate the practice of sealing a deal with a handshake, as a mark of trust (1). We see this in Egypt, Mesopotamia and Greece, but also in Viking Age Scandinavia. However, the handshake as practised within our own cultural sphere today, was introduced much later, possibly by Quakers in the 17th century (1).

Gradually, the handshake also came to play a natural role in healthcare settings, but this changed with the advent of the coronavirus pandemic. In early March 2020, it became clear that Norway was facing a severe health threat from COVID-19. On 12th March 2020, the Government introduced the most intrusive control measures ever seen in Norway in peacetime, with contact-reducing measures as an important part of the strategy. As early as 5 March, Oslo University Hospital decided that their own healthcare personnel should no longer shake hands with patients (2). The Patient Ombudsman of Oslo and Akershus, Anne-Lise Kristensen, was impatient and spoke out on national television a day later, calling for clear national guidance from the Director of Health (3). Soon after, such guidance was put in place.

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All mandatory coronavirus measures were lifted by the Government on 12 February 2022. Nevertheless, healthcare personnel should keep up appropriate infection control routines introduced during the pandemic, including good hand hygiene – despite hand hygiene being likely to have subordinate significance in reducing the transmission of COVID-19 (4, 5). The SARS-CoV-2 virus is primarily transmitted by virus-containing droplets over short distances of 1–2 metres, but also through air over longer distances. The relative significance of these two transmission routes, known as droplet and airborne transmission respectively, is still hotly debated among specialists, and the terminology is currently in flux (6).

However, it cannot be overemphasised that hand hygiene plays an important part in preventing healthcare-associated infections in the wider sense. The story of the Austro-Hungarian doctor Ignaz Semmelweis is well known: In the mid-19th century, he reduced the incidence of fatal postpartum infections by ordering students who had taken part in post-mortem examinations to disinfect their hands with chlorinated lime before they were allowed to assist at childbirths. Healthcare-associated infections remain common complications in healthcare facilities (7), and antibiotic resistance may well be the greatest threat to modern medical treatment. In 2015, estimates showed that in the EU and EUA, there were more than 670 000 cases of infection with antibiotic-resistant bacteria, and of these, approximately 33 000 were fatal (8).

Good hand hygiene can prevent both healthcare-associated infections and the spread of antibiotic-resistant bacteria. According to the handbook for hand hygiene published by the Norwegian Institute of Public Health, this is our most important, simplest and most cost-effective infection control measure (7). The handbook emphasises that 'even brief skin-to-skin contact by shaking someone's hand or measuring their blood pressure and heart rate, is sufficient to contaminate the hands of healthcare personnel with potentially pathogenic bacteria' (7). It is therefore difficult to understand why national and local infection control guidelines do not more clearly warn against handshaking in healthcare settings. Perhaps it is taken for granted that the handshake is immediately followed by disinfection or washing of hands. But for many, having to 'cleanse themselves of the patient' will not only remove microorganisms but also undo much of what the handshake sought to achieve. It is therefore likely that hand hygiene standards will tend to suffer, and that bacteria exchanged by handshakes are spread to computer keyboards, other surfaces and new hands. In a worst-case scenario, this may lead to life-threatening infections in vulnerable patients.

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It is therefore encouraging that a study now being published in the Journal, shows that doctors at St Olav's Hospital currently shake hands with patients much less frequently than before the COVID-19 pandemic (9). Nobody knows how long this will last, or if greeting habits among doctors at St Olav's Hospital are representative of healthcare personnel in other parts of the country. To ensure a lasting change in greeting habits, we need more explicit guidelines from national infection control authorities to make it clear that handshaking is an inappropriate form of greeting in healthcare settings. There are good alternatives that involve no physical contact. In most cases it will be enough to introduce oneself and to greet patients with a friendly, sympathetic and interested gaze.

Handshaking in healthcare settings is an inappropriate ritual with potentially fatal outcomes. We need to keep up the practices and lessons learnt from the COVID-19 pandemic and establish a new greeting culture that does not involve an exchange of handshakes.

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