The emperor's new clothes: workwear and uniforms guidelines undressed

This article summarizes patient and physician opinions of what constitutes appropriate attire in the clinical environment. It evaluates the Department of Health workwear and uniforms policy, including the evidence and inconsistencies which underlie these guidelines, and attempts to predict future trends.

On 6 August 2009 some junior doctors began new posts feeling somewhat underdressed. At the authors' institution each individual came dressed for work according to their previous trust's interpretation of the Department of Health (2007) uniforms and workwear guidelines. Many doctors arrived smartly suited while others dressed in strict accordance to the policy, wearing short-sleeved shirts, and no neck ties or wristwatches. The apparent confusion as to exactly what constitutes appropriate clinical attire inspired the following exploration of clinical dress codes and the Department of Health uniforms and workwear guidelines.

History

The evolution of clinical attire can be radically demonstrated by the disparity between an 18th century barber surgeon's unhygienic bloody apron (*Figure 1*) and the 21st century immaculately suited hospital consultants scrubbing their hands with sanitization gel. Over 200 years later, the only acceptable alcohol between patients is found in a convenient 350 ml pump bottle at the end of a hospital bed.

The adoption of the suit and tie or equivalent as the most appropriate attire in professional settings was fostered because of the political and social dominance of the west during the previous century. Clothing can be a very personal issue for clinicians and acts as a marker of status and power for individuals in the public arena. In western societies how one presents oneself is often seen as a reflection of the individual.

Contemporary evidence

As demonstrated by Gjerdingen and Simpson (1989) and Major et al (2005), physicians have an established preference for formal attire founded on the assumptions patients may form regarding professionalism and trustworthiness based on appearance. Both patients and physicians consider dress to be an import part of the doctor–patient relationship. Colt and Solot (1989) and Nihalani et al (2006) demonstrated that clinicians are often more critical of their own professional image than patients. Public opinion and observational evidence suggests that popular clinical attire such as white coats and neck ties are desirable but may pose a risk of cross contamination.

Hospital hygiene and more specifically clinical dress codes have never been more topical. Following well-publicized outbreaks of methicillin-resistant *Staphylococcus aureus* and *Clostridium difficile*, various demands and claims have been made to regulate how doctors dress with a view to reducing the spread of hospital-acquired infection. In September 2007 the Secretary of State for Health announced the introduction of a range of measures for NHS hospitals including a 'bare below the elbows' dress code for those involved in clinical activity in all acute hospital trusts by January 2008 (Hansard, 2007) (*Table 1*). The British Medical Association (2008) has expressed concerns regarding this policy, particularly the lack of scientific evidence to support these changes, which may have been issued hastily in response to an intense period of media focus.

Surveys by Neinstein et al (1985) and Matsui et al (1998) demonstrated that parents, children and adolescents tend to have a relatively neutral attitude towards

Figure 1. Franz Anton Maulbertsch: The Quack (1785). Shows barber surgeons at work.

Mr Geraint Williams *is Speciality Trainee Year Two in Trauma and Orthopaedics and* **Mr Neil Jarvis** *is Speciality Trainee Year Three in Trauma and Orthopaedics, Mid Cheshire NHS Trusts, Leighton Hospital, Crewe, Cheshire CW1 4QJ*

Correspondence to: Mr G Williams

Table 1. Key points of the Department of Health document *Uniforms, work-wear and evidence base for developing local policy*

Wear short-sleeved shirts (bare below the elbows), no white coats
Change immediately if clothes become soiled or contaminated
Wash working clothes at the hottest temperatures suitable for the fabric
Do not wear neck-ties in any care activity involving patient contact
Do not wear wrist jewellery or a watch, wedding bands are acceptable

From Department of Health (2007)

doctors' dress code, showing little preference for either formal or casual dress. Similar surveys by McNaughton-Filion et al (1991) and Nihalani et al (2006) conducted on adult patients clearly show a patient preference for more formal physician attire. McKinstry and Wang (1991) demonstrated that older patients have conservative attitudes to clinical dress codes, this being particularly relevant for patients with managerial or professional vocations.

Sanders et al (1991), Cha et al (2004) and Li and Haber (2005) found that many patients do express a preference for traditional, formal dress, but controlled studies found this preference to have no overall impact on patient satisfaction, comfort or confidence in the physician. The most recent observational surveys suggest that traditional patient attitudes towards clinical attire are changing.

In 2002 Nair et al coined the term 'evidence-based dressing' in relation to the items of clothing necessary to arouse reasonable levels of professionalism and trustworthiness during the doctor–patient consultation. They found that a minimum of two or more items of formal attire (tie, shirt, trousers, shoes or white coat) are required to inspire a reasonable amount of confidence in the clinician. Possibly the most important study conducted to date was performed by Fischer et al (2007). The authors conducted a randomized controlled trial involving twenty clinicians and over 1000 patients. They found no significant difference in patient satisfaction scores after doctor–patient consultations regardless of demographic factors, formal or more casual attire.

Wong et al (1991) and Dixon (2000) both highlight that infrequently washed traditional garments such as white coats and neck ties (*Figure 2a*) are a significant potential source of cross infection as they quickly become heavily contaminated with multiple strains of bacteria. Screening, decolonization and isolation of infectious patients in combination with frequent hand washing are the main preventative procedures to combat risks of cross contamination. Less robust data (Wang and Barrett, 2007) suggest that trusts' policies could include measures to expand glove and apron use along with other barrier methods to augment these simple procedures. Face masks, surgical hats, gowns (*Figure 2b*) and isolation exhaust suits used in joint replacement surgery significantly reduce bacterial shedding and the development of colony-forming units on surgical wounds in theatre environments (Hubble et al, 1996; Malik et al, 2005). If an emphasis on being 'seen to be clean' continues to take precedence over evidence-based policy there may come a point at which the hospital begins to resemble a microbiological weapons factory with exhaust suit-clad clinical staff roaming the wards (*Figure 2c*).

Figure 2. a. Traditional clinical attire: long-sleeved shirt and tie. b. Modified dress code with additional protective garments. c. Future possibility. Will physicians eventually be wearing surgical isolation exhaust suits for clinical duties in the interests of infection control?

Discussion

Implementation of the Department of Health's bare below the elbows dress code is inconsistent between NHS trusts. Currently each trust has its own interpretation of these guidelines with no national continuity. To increase confusion some aspects of Department of Health policy are in contrast with the available evidence. For example, the omission of wrist watches because of their tendency to harbour infectious pathogens is a plausible concept, but this contradicts the recommendation to allow wedding bands which act in much the same capacity.

It has yet to be established if the development of a dress codes for clinicians, the omission of ties, watches or other potential havens for bacteria from clinical areas will have any impact on cross contamination or infection rates. These issues must be addressed in order to promote evidence-based, nationally agreed dress codes for clinical areas with clear non-contradictory instructions as to what is and what is not acceptable attire in the workplace. The available data must be considered in a balanced way and not over-emphasized such that the principles of infection control are undervalued in preference for dramatic but ineffective visual measures (*Figure 2c*).

Conclusions

Currently the evidence for a modified clinical dress code is weak. Conspiracy theorists might suggest these modifications are a managerial ploy such that a more casual dress code will diminish the consultant's physical presence as a figure of authority in a trust meeting with power-dressed managerial executives. Ruminations aside, if a clinician feels that losing his tie makes him somewhat less appealing, simply wearing a smile is a proven method to significantly increase patient comfort and physician appearance (Lill and Wilkinson, 2002). **BJHM**

Conflict of interest: none.

British Medical Association (2008) Uniform and dress code for doctors. Guidance from the Central Consultants and Specialists Committee. British Medical Association, London (www.bma.org.uk/employmentandcontracts/working_arrangements/CCSCdresscode051207.jsp accessed 27 July 2009)

Cha A, Hecht B, Nelson K, Hopkins M (2004) Resident physician attire: does it make a difference to our patients? *Am J Obstet Gynecol* **190**(5): 1484–8

Colt H, Solot J (1989) Attitudes of patients and physicians regarding physician dress and demeanor in the emergency department. *Ann Emerg Med* **18**(2): 145–51

Department of Heath (2007) Uniforms and workwear: an evidence base for developing local policy. Department of Health, London (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_078433 accessed 27 July 2009)

Dixon M (2000) Neck ties as vectors for nosocomial infection. *Intensive Care Med* **26**(2): 250

Fischer R, Hansen C, Hunter R, Veloski J (2007) Does physician attire influence patient satisfaction in an outpatient obstetrics and gynecology setting? *Am J Obstet Gyneco* **196**(2);186: 1–5

Gjerdingen D, Simpson D (1989) Physicians' attitudes about their professional appearance. *Fam Pract Res J* **1:** 57–64

Hansard (2007) 21 November 2007: Column 1262. (www.publications.parliament.uk/pa/cm200708/cmhansrd/cm071121/debtext/71121-0016.htm accessed 27 July 2009)

Hubble M, Weale A, Perez J, Bowker K, MacGowan A, Bannister G (1996) Clothing in laminar-flow operating theatres. *J Hosp Infect* **32**(1): 1–7

Li SF, Haber M (2005) Patient attitudes toward emergency physician attire. *J Emerg Med* **29**(1): 1–3

Lill M, Wilkinson T (2002) Judging a book by its cover: descriptive survey of patients' preferences for doctors' appearance and mode of address. *BMJ* **24**;331(7531): 1524–7

Major K, Hayase Y, Balderrama D, Lefor A (2005) Attitudes regarding surgeons' attire. *Am J Surg* **190**(1): 103–6

Malik M, Chougle A, Pradhan N, Gambhir A, Porter M (2005) Primary total knee replacement: a comparison of a nationally agreed guide to best practice and current surgical technique as determined by the North West Regional Arthroplasty Register. *Ann R Coll Surg Engl* **87**(2): 117–22

Matsui D, Cho M, Rieder M (1998) Physicians' attire as perceived by young children and their parents: the myth of the white coat syndrome. *Pediatr Emerg Care* **14**(3): 198–201

McKinstry B, Wang J (1991) Putting on the style: what patients think of the way their doctor dresses. *Br J Gen Pract* **41**;(348)270: 275–8

McNaughton-Filion L, Chen J, Norton P (1991) The physician's appearance. *Fam Med* **23**(3): 208–11

Nair B, Attia J, Mears S, Hitchcock K (2002) Evidence-based physicians' dressing: a crossover trial. *Med J Aust* **177**(11-12): 681–2

Neinstein LS, Stewart D, Gordon N (1985) Effect of physician dress style on patient-physician relationship. *J Adolesc Health Care* **6**(6): 456–9

Nihalani N, Kunwar A, Staller J, Lamberti J (2006) How should psychiatrists dress?--a survey. *Community Ment Health J* **42**(3): 291–302

Sanders L, Gildersleve C, Rees L, White M (1991) The impact of the appearance of the anaesthetist on the patient's perception of the pre-operative visit. *Anaesthesia* **46**(12): 1056–8

Wang L, Barrett J (2007) Control and prevention of MRSA infections. *Methods Mol Biol* **391:** 209–25

Wong D, Nye K, Hollis P (1991) Microbial flora on doctors' white coats. *BMJ* **303**(6817): 1602–4

KEY POINTS

- Implementation of the Department of Health's 'bare below the elbows' dress code is inconsistent between NHS trusts.
- It has yet to be established whether a modified dress code will have an impact on cross contamination or infection rates.
- Clear, evidence-based, nationally agreed dress codes for clinical areas should be developed with instruction as to what is and what is not acceptable attire in the workplace.