

The way doctors dress: stakeholder preferences and the impact on their perceptions

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Abstract

Background: Doctors' appearance and attire is known to facilitate a good relationship between doctors and patients, which can lead to better health outcomes. Doctor attire seems to have changed over time in line with patients' preferences and health policies. These preferences, however, vary according to location, patient's age and context of medical care. In the U.K., the government dress code policy prescribes adherence to "bare below the elbows" practice and no longer advocates the use of white coats. This is not based on any conclusive evidence, but Hospital Trusts dictate dress code policies accordingly. We have tried to explore attitudes of patients, carers and healthcare staff towards doctors' dress code in a general hospital and a psychiatric hospital to inform national and international debate on the medical dress code policy.

Objective: To ascertain patients, carers and staff preferences for doctors' dress code in two different (general & psychiatric) acute hospital settings and the effect of those preferences.

Methods: A descriptive cross-sectional survey questionnaire based on previous research was handed out to 347 patients, carers and medical/psychiatric healthcare professionals. The main outcome was for the participants to select their preferred dress code. The secondary outcome was to identify how dress codes influenced their perceptions of doctors.

Results: Our response rate was 94% as 337 out of 360 subjects participated in the survey. Overall, 40% (n=135) preferred formal dress, 29% (n=99) preferred smart casual, 17% (n=58) preferred white coat and 13% (n=45) of participants had no preference.

Conclusions: In both general and psychiatric hospitals, patients, carers and staff preferred a formal dress code for doctors.

Introduction

The way a doctor dresses is a fundamental part of establishing therapeutic alliance with patients.^{1,2} It has been shown that doctor's dress can influence patient confidence, offer greater reassurance, higher levels of trust, better adherence to prescribed medication regimens, enhanced willingness to complete return visits, and discuss sensitive issues.^{3,4} The literature outcomes in this field are mixed; for example, some studies suggest a non-correlation with perceived courteousness or professionalism,^{5,6} but we believe there is enough evidence to suggest that the manner in which a doctor dresses forms an important part of non-verbal communication, which is important for their interaction with patients, carers and with other staff members.

Various studies have examined patient preferences towards doctors' dress. Formal dress or a white coat have been cited as favoured due to their perceived association with empathy, competence and trust.^{2,4,7,8} This is in contrast to other studies which found semiformal dress as preferred.⁹

In psychiatry, studies of inpatients have indicated a preference for smart attire and white coats as part of their doctors' dress code.^{10,11} McGuire *et al* also found that community patients preferred their psychiatrists to be dressed as "smart/formal".¹²

In recent years, dress code policy for doctors in the UK has become more informal, and white coats have been abolished for a number of reasons.¹³ In this study, we sought to determine the attitudes of multiple stakeholders towards doctors' dress in both general and psychiatric hospital settings.

Methods

We surveyed healthcare staff, patients, and carers in an emergency department at a district general hospital ("medical setting"), and in a psychiatric hospital ("psychiatric setting") in the South East of England. The data was collected on a week day between 09.00 and 17.00 at both settings, using a questionnaire based on Rehman *et al*.¹⁴ There were no exclusion criteria.

The survey questionnaire sampled demographic details, and used nine questions and two sets of images (a male doctor & a female doctor) depicting three styles of dress; white coat, formal (tie & trousers for male; dark skirt and white shirt for female) and smart casual ("bare below the elbows"). The survey questionnaire was piloted amongst volunteer staff and assessed for their user-friendliness and ease of comprehension before use. It was amended in line with the feedback received.

Table 1. Dress code preferences among all stakeholders.

| Location | Dress code preference | | | | Total | Within-group p value | Between-group p value |
|-------------|-----------------------|-------------------|---------------|----------------------|-------|----------------------|-----------------------|
| | <i>Smart casual</i> | <i>White coat</i> | <i>Formal</i> | <i>No preference</i> | | | |
| Medical | 42 | 40 | 59 | 26 | 167 | <0.01 | - |
| Psychiatric | 57 | 18 | 76 | 19 | 170 | <0.001 | - |
| Total | 99 | 58 | 135 | 45 | 337 | - | <0.001 |

P values were calculated using Chi-squared test. NS = not significant ($p > 0.05$).

Table 2. Dress code preferences among staff.

| Location | Dress code preference | | | | Total | Within-group p value | Between-group p value |
|-------------|-----------------------|-------------------|---------------|----------------------|-------|----------------------|-----------------------|
| | <i>Smart casual</i> | <i>White coat</i> | <i>Formal</i> | <i>No preference</i> | | | |
| Medical | 22 | 10 | 27 | 7 | 66 | <0.001 | - |
| Psychiatric | 22 | 4 | 35 | 3 | 64 | <0.001 | - |
| Total | 44 | 14 | 62 | 10 | 130 | - | NS |

P values were calculated using Chi-squared test. NS = not significant ($p > 0.05$).

Table 3. Dress code preferences among patients.

| Location | Dress code preference | | | | Total | Within-group p value | Between-group p value |
|-------------|-----------------------|-------------------|---------------|----------------------|-------|----------------------|-----------------------|
| | <i>Smart casual</i> | <i>White coat</i> | <i>Formal</i> | <i>No preference</i> | | | |
| Medical | 14 | 14 | 15 | 10 | 53 | NS | - |
| Psychiatric | 16 | 9 | 24 | 10 | 59 | <0.05 | - |
| Total | 30 | 23 | 39 | 20 | 112 | - | NS |

P values were calculated using Chi-squared test. NS = not significant ($p > 0.05$).

Table 4. Dress code preferences among carers.

| Location | Dress code preference | | | | Total | Within-group p value | Between-group p value |
|-------------|-----------------------|-------------------|---------------|----------------------|-------|----------------------|-----------------------|
| | <i>Smart casual</i> | <i>White coat</i> | <i>Formal</i> | <i>No preference</i> | | | |
| Medical | 6 | 16 | 17 | 9 | 48 | NS | - |
| Psychiatric | 19 | 5 | 17 | 6 | 47 | <0.01 | - |
| Total | 25 | 21 | 34 | 15 | 95 | - | <0.01 |

P values were calculated using Chi-squared test. NS = not significant ($p > 0.05$).

Table 5. Doctor attributes associated with different dress codes.

| Dress code | Associated doctor attribute | | | | | | | | Total |
|--------------|-----------------------------|---------------|--------------|---------------|---------------|---------------|--------------|--------------|-------|
| | <i>Trust</i> | <i>Advice</i> | <i>Conf.</i> | <i>Return</i> | <i>Knowl.</i> | <i>Caring</i> | <i>Resp.</i> | <i>Auth.</i> | |
| Smart casual | 77 | 57 | 59 | 74 | 49 | 109 | 51 | 38 | 514 |
| White coat | 74 | 91 | 89 | 77 | 107 | 65 | 87 | 103 | 693 |
| Formal | 142 | 138 | 142 | 134 | 132 | 110 | 143 | 145 | 1086 |

Respondents were shown images of each dress code asked "Which doctor would you...": Trust the most (trust), Follow the advice of (advice), Have confidence in their diagnosis and treatment (conf.), Return to for follow-up care (return), Regard as knowledgeable & competent (knowl.), Regard as caring & compassionate (caring), Regard as responsible (resp.), Regard as authoritative & in control (auth.). $P < 0.0001$ (calculated using Chi-squared test). Results were excluded for where more than one dress code was selected for an attribute, or where no choice was made.

Results

337 individuals responded to the questionnaire, giving a response rate of 94%. Our sample was predominantly white (72%), female (62%) and married (43%). Respondent age, ethnicity and employment status were broadly representative of the local population.

Overall (Table 1), we found that the majority of respondents felt that the way that doctors dress was important to them, and that the location of respondents significantly affected their preferences ($p < 0.001$). Although in these overall results there was no majority preference for one dress code over another in either location, preferences within each varied significantly (medical: $p < 0.01$ and psychiatric: $p < 0.001$). This numerical

preference appeared to be for formal dress in both settings, capturing 35% and 45% of respondent vote respectively.

Within the three stakeholder-specific breakdowns (Tables 2-4), differences in preference reached significance for medical staff ($p < 0.001$), psychiatric staff ($p < 0.001$), psychiatric patients ($p < 0.05$), and psychiatric carers ($p < 0.01$). Like the overall results, there was no majority preference in any of these groups, but formal dress captured the highest numerical vote in medical staff (41%), psychiatric staff (55%), and in psychiatric patients (41%). Psychiatric carers preferred formal and smart casual dress broadly equally, which captured 36% and 40% of the vote respectively. Carers were the only stakeholder whose preferences were significantly influenced by their location ($p < 0.01$).

Dress code statistically significantly influenced the attributes associated with the doctor wearing them ($p < 0.0001$), as shown in *Table 5*. Formal dress captured the greatest proportion of every attribute tested, and considering total responses, formally dressed doctors were almost twice as likely to be associated with these attributes as those dressed in smart casual or a white coat.

52% of respondents were not aware that a doctors' dress code policy existed, and while 53% of respondents felt they should not be consulted when considering dress code, 41% believed they should. 59% of respondents believed doctors adhered to their sites' dress code policies, while 27% did not think so.

Discussion

To our knowledge, this is the first study in the world to compare preferences in doctors' dress code between a psychiatric hospital and a medical hospital. Also, no other study to our knowledge has simultaneously explored the attitudes of different key stakeholders in both medical and psychiatric settings regarding this important issue.

In this study, we have successfully captured the attitudes and perceptions of key stakeholders regarding doctors' dress code. We found that overall, doctors' dress code was felt to be important, and that in medical and psychiatric locations a formal dress code is preferred. Looking at staff, patients and carers specifically, we found a preference for formal dress among medical staff, psychiatric staff, and in psychiatric patients. Among psychiatric carers, formal dress was preferred equally to smart casual. There were no significant preferences among the other stakeholders surveyed.

This preference for formal dress is easily explained by the results shown in *Table 5*. Seeing a doctor in formal dress made it almost twice as likely that that doctor would be seen as possessing any of the eight positive attributes included. Clearly, in the eyes of the respondents to our survey, a formally dressed doctor was most likely to provide good care.

Discussion (continued)

Interestingly, we also found that the location of healthcare influenced the preferences of carers to such an extent that it offset the non-significant results among staff and patients; such that this significance was carried through to the overall results. Exploring this in more detail, we see a marked preference for smart casual in the psychiatric setting over the medical setting (40% vs. 13%), for a white coat in the medical setting over the psychiatric setting (33% vs. 11%), and an almost equal preference for formal dress in both. This starkness in difference in preference between care locations indicates differences in the cultural perceptions of doctors by carers, but not by staff or patients. Perhaps an explanation for this difference is that historically, carers have been more involved and influential in the psychiatric setting, being an essential component to care, whereas in the medical setting they have tended to be more passive partners in care. A negative perception of mental health care portrayed to the public through film and media may have

driven preferences away from white coat in the psychiatric setting, whereas in the medical setting perhaps a positive association with the white coat and physical health may have done the opposite.

Conclusion

We have identified a clear preference for a formal dress code for doctors from all stakeholders at medical and psychiatric care locations studied. However, we identified several interesting variations in preferences among individual stakeholders, and found that the location of care significantly impacted the preferences of carers. We believe these findings could be harnessed in the future development of dress code policies for doctors in order to enhance the doctor-patient relationship, and to improve the quality of doctors' relationships with both carers and with other staff members. Additionally, there may be merit in involving these stakeholders during the policy development process.

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None

Competing Interests

None declared

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