Doctor's Attire and Patient Safety

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Koh and others[1] have reported (in this issue of the MJM) the high prevalence of Methicillin resistant *Staphylococcus aureus* (MRSA) on doctors' neckties. As they have pointed out, this is nothing new, and like other studies with similar findings. They also point out that patient's confidence and satisfaction are not affected by doctor's not wearing neckties. They also referred to the British Department of Health decision to ban the use of neckties, long sleeve shirts and jewellery, and the Scottish government's intention to ban the wearing of white coats, including neckties, to stop the spread of infections. They support the call by The Malaysian Medical Association to avoid the use of neckties.

The doctor-patient relationship is the basic foundation for professional patient care. Wearing professional dress including a white coat may favourably influence trust and build confidence in the doctor-patient encounter[2], and promotes the development of this relationship. Most doctors wear white coats for easy recognition by colleagues and patients and for convenience, however psychiatrists and paediatricians attempt to develop rapport by deliberately not wearing white coats[3]. In studying the views of doctors and patients on the wearing of white coats, Douse *et. al.*[4] found that doctors viewed white coats as an infection risk. However, most patients felt that doctors should wear white coats for easy identification.

The Department of Health in England had issued new guidelines on the clothing of staff, including doctors in the National Health Service (NHS)[5]. The policy suggests doctors should wear short sleeved shirts, avoid white coats and stop wearing watches. This policy was based on a scientific literature review by researchers funded by The Department of Health[6,7]. Swindells and Rajan[8] looked at the patients' perceptions with regard to their feeling of safety from infection, in relation to the NHS guidelines[5]. They found that while a significant member of patients prefer their doctor to wear white coats, patients do not value doctor's attire highly and only a minority of patients felt safer from infection as a result of the new guidelines[8].

It would appear that more research need to be done on doctors' views as well as on patient's views on doctors' attire, and on whether patient education can change the patient's views[8], particularly in our local setting.

Despite advances in medicine and in public health, infections in hospitalised patients result in significant morbidity and mortality. Ducel *et. al*[9] cited a prevalence survey conducted under the auspices of the WHO in 55 hospitals in 14 countries in 4 WHO Regions (Europe, Eastern Mediterranean, South-East Asia and Western Pacific) which showed an average of 8.7% of hospital patients with nosocomial infections. Petroudi[10] in a review of nosocomial infections and staff hygiene emphasised hand washing as the single most important measure to prevent nosocomial infections, and observed that compliance to this practice is unacceptably low, at less than 50% in studies over the last 20 years. The complexities of infection control is obviously very challenging. Semmelweis (1818-1865) working in The University of Vienna demonstrated the importance of hand washing in reducing mortality among his obstetric patients. His colleagues were not impressed, and Semmelweis was even dismissed from his position[11].

Joseph Lister (1827-1912) worked on the antiseptic principle, showed the effectiveness of protecting open fractures from bacteria, using carbolic acid. These impressive results were published in 1967. However, his methods were very slow to be accepted, by the Germans in the 1870's and later followed by The USA, France and eventually England[12]. This inherent conservatism and reticence to change that is often observed in the history of medicine is not consistent with our modern emphasis an evidence based medicine. However it needs to be understood and taken account of in managing the process of change, if change is to successfully occur in implementing new ideas.

The concern for patient safety, which really had been a long time in coming, despite a lot of work being published about it, had received wide attention following reports from the Institute of Medicine in the USA[13,14], which made recommendations on a comprehensive approach to improving patient safety. In May 2002, the fifty fifth World Health Assembly adopted WHA resolution 55.18, which urged member states to improve patient safety and quality of health care. In May 2004, the fifty seventh World Health Assembly supported the creation of an international alliance to facilitate the development of patient safety policy and practice in all member States, and to be a major force for improvement internationally.

The great concentration of attention on patient safety and the global response, initiated by The World Health Organisation (WHO) call for action on Patient Safety have generated the necessary sense of urgency in improving patient safety and quality in health care. As part of this, all hospitals should have in place properly organised infection control systems, with infection controls programmes, nosocomial infection surveillance, prevention of nosocomial infection, practical aspects of infection control and plans on dealing with outbreaks. A manual on the prevention of

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hospital acquired infections should be available as a resource for all units within a hospital[9]. In the context of these guidelines, each hospital should have practical guidelines on the attire of doctors and other hospital staff, which is appropriate for the different work to be done in different parts of the hospital. As far as possible these guidelines should be evidence based. While enhancing the doctor-patient relationship is very important, patient safety is critically important and should be our paramount interest. More research need to be done in these areas, and the report by Koh and others1 is a good reminder to us all on these important and sometimes overlooked issues.

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