## SARTORIAL ELEGANCE — A REVIEWER'S VIEW

**Ms Leanne Scott, of the Department of Statistical Sciences, University of Cape Town, comments:** This study examines the attitudes of 100 antenatal patients to what their doctors wear and how the patients prefer to be addressed. However, there are a number of points about this study that could be said to confound the picture.

The study is fundamentally flawed in that it presents respondents (patients) with a very limited view of the issues under discussion. The fact that patients were asked to equate dress with 'most trustworthy, most competent, most friendly' reinforces inappropriate associations between these variables. There is an implicit and unquestioned assumption that it is possible to predict these character traits on the basis of dress. By not giving respondents the opportunity to question this assumption, the study actively perpetuates it. The design even excludes those patients who attempt to say that there is no legitimate association between these variables by nominating all photographs equally, for example, 'friendly'.

The authors recognise the need to attempt to control for the fact that doctors' current dress may influence patients' perceptions. Accordingly interviews were conducted on the first antenatal visit, before patients had contact with medical personnel. However it is extremely likely that patients would have had prior perception of and exposure to what doctors are known to wear in hospitals. Therefore the conclusion 'so that staff dress would not influence their decisions' is not justified.

In my opinion the authors also correctly state 'We may be criticised for not directly evaluating the acceptability of an informally dressed doctor wearing a white coat.' This is a definite weakness of the study. The fact that respondents *did* indicate a (significant) preference for formal clothes with a white coat (option 1), but did *not* (significantly) prefer formal clothes without a white coat (option 2), suggests that the overwhelming factor here is the white coat and its long association with medical expertise.

The usual way to deal with ties in the data is to split the vote (i.e. assign a half a vote to each of the nominated options). This study deals with ties by assigning a full vote to each nominated option (photo), and increasing the sample size. The effect of this procedure is to allocate two votes to that particular patient, giving patients who are less decisive more voting power than those who are more decisive! It is difficult to see the justification for this.

This study tries to assess patients' preferences, which is laudable. However it is something of a red herring to measure preference by criteria which cannot be shown to be related to quality of health care.

The Pretoria University Medical Ethics Committee approved the study, and all the patients gave written informed consent.

There were five photographs of each of the two doctors, so we assumed that each photograph would be assigned one-fifth (20%) of the votes by chance.[6] In testing the findings we used chi-square tests to compare proportions and *P*-values and confidence intervals (CIs) to describe results significantly different from what would be expected by chance.

## WHAT THEY TOLD US

All 100 patients who were asked to enter the study agreed to participate. The average age was 27 years and average gestational age was 30 weeks. Five per cent of patients had received no formal education, 12% had primary education, 77% secondary and 6% tertiary education. Forty-five per cent were unemployed and a further 20% were unemployed but studying.

Seventy-six per cent of patients said that they would prefer to be addressed by their first names, while 19% preferred their first name preceded by either *mama* or *sisi*. Only 6% said that they would want to be addressed by their surnames.

Eighty-six per cent of patients felt that doctors' clothing was important and 89% said that doctors should wear name tags, whatever they were wearing.

**Female dress.** Table III shows patient preference for female dress. Formal clothing consisting of either a skirt, blouse and closed white coat, or a skirt and safari suit top, scored consistently better for all attributes, often reaching statistical significance. These two forms of dress were also chosen statistically significantly more often than can be attributed to chance as regards preferred dress for a female doctor. Less formal clothing performed consistently worse for all attributes, reaching statistical significance on numerous occasions. When overall preferences for female doctors' dress were calculated, all three casual outfits were chosen statistically significantly less often than would be anticipated by chance. A causal shirt, blue denims and track shoes was the least popular choice for all attributes.

**Male dress.** Table III also shows patient preferences with regard to male dress. Formal clothing consisting of either long pants, shirt, tie and closed white coat, or long pants and safari suit top, scored consistently better for all attributes, with the former reaching statistical significance in all but one of the attributes. When overall preferences were calculated the long pants, shirt, tie and white coat were chosen statistically significantly more often than can be attributed to chance. Although long pants and safari suit top was the second choice, this did not reach statistical significance. Informal dress consisting of either long pants and open-neck shirt or casual

**Table III. Patient preferences with regard to dress of male and female doctors**

| Outcome of preferences for female attire | Trust | Competence | Friendly | Relationship | Total | 95% CI |
|---|---|---|---|---|---|---|
| A | *45/107 (0.42) | 35/99 (0.35) | *42/102 (0.42) | * 46/108 (0.43) | *168/416 (0.40) | 0.36 - 0.45 |
| B | 15/107 (0.14) | 13/99 (0.13) | †11/102 (0.11) | 14/108 (0.12) | †55/416 (0.13) | 0.10 - 0.16 |
| C | †8/107 (0.07) | †7/99 (0.07) | †10/102 (0.10) | †8/108 (0.07) | †34/416 (0.08) | 0.06 - 0.11 |
| D | *38/107 (0.35) | *39/99 (0.39) | *37/102 (0.37) | *38/108 (0.35) | *152./416 (0.37) | 0.32 - 0.41 |
| E | †1/107 (0.01) | †2/99 (0.02) | †2/102 (0.02) | †2/108 (0.02) | †7/416 (0.02) | 0.01 - 0.02 |
| Spoilt ballots | 12/100 (12%) | 16/100 (16%) | 11/100 (11%) | 8/100 (8%) | | |
| Pairs | 19/100 (19%) | 15/100 (15%) | 13/100 (24%) | 16/100 (16%) | | |
| Denominator | 107 | 99 | 102 | 108 | 416 | |
| **Outcome of preferences for male attire** | | | | | | |
| A | *51/117 (0.44) | *45/108 (0.42) | *48/115 (0.42) | *49/116 (0.42) | *193/456 (0.42) | 0.38 - 0.47 |
| B | 23/117 (0.20) | 23/108 (0.21) | 23/115 (0.20) | 22/116 (0.19) | 91/456 (0.20) | 0.16 - 0.24 |
| C | †10/117 (0.09) | †8/108 (0.07) | †6/115 (0.05) | †8/116 (0.07) | †32/456 (0.07) | 0.05 - 0.09 |
| D | 30/117 (0.26) | 28/108 (0.26) | 33/115 (0.29) | 32/116 (0.28) | 123/456 (0.27) | 0.23 - 0.31 |
| E | †3/117 (0.03) | †4/108 (0.04) | †5/115 (0.04) | †5/116 (0.04) | †17/456 (0.04) | 0.02 - 0.05 |
| Spoilt ballots | 9/100 (9%) | 14/100 (14%) | 9/100 (9%) | 8/100 (8%) | | |
| Pairs | 26/100 (26%) | 22/100 (22%) | 24/100 (24%) | 24/100 (24%) | | |
| Denominator | 117 | 108 | 115 | 116 | 456 | |

Where patients could not assign a preferred dress code for a particular attribute, or assigned more than two dress codes as best representing an attribute, this was taken to indicate a spoilt ballot for that attribute. Spoilt ballots were excluded from the denominator. Patients were allowed to choose two dress codes to best represent an attribute, the number of times two dress codes were chosen for a particular attribute is marked as pairs. The denominator consists of the 100 patients plus the number of pairs, minus the number of spoilt ballots. Bracketed numbers indicate the proportion of patients that selected a particular dress code for an attribute. It was assumed that each dress code would be assigned 20% of the votes by chance. An asterisk (*) marks where a particular dress code has been chosen statistically significantly ($P < 0.05$) more often than can be attributed to chance, while † indicates where a dress code has been chosen statistically significantly ($P < 0.05$) less often than can be attributed to chance. 95% CI = 95% confidence intervals around the proportions.

shirt and blue denims was chosen statistically significantly less often than can be attributed to chance for all attributes and overall preference as regards male doctors' dress. Casual shirt, blue denims and track shoes was the least popular choice for all attributes.

## WHAT OUR PATIENTS PREFER

Most of our patients prefer to be addressed either by their first name alone or by a prefix followed by their first name. First names are used to address children and subordinates or to establish informality, familiarity and closeness, while surnames are used to address older people and superiors and to convey formality, respect and distance.[7] It is possible that black people anticipate that whites in positions of authority will address them by their first name.[3] However, in training hospitals in the USA patients also expressed a reluctance to be addressed by their surnames. A possible explanation for this is that sick patients want to be relieved of the usual adult social responsibilities.[3,8] Although only 6% of patients in this study wanted to be addressed by their surnames, these patients may be deeply offended by the unsanctioned use of their first name, so it is advisable when first seeing a patient to ask what form of address he or she would prefer.

Our patients preferred more formal dress, expecting a doctor to look like a traditional doctor. A more formally dressed doctor (either male or female), wearing a white coat, was the overall preference, although formal pants or skirt with a safari suit top appears to be acceptable. This may reflect cultural expectations, which do not differ greatly from what British and American patients expect of their doctors.[9-11] The white coat is practical — items can be placed in the pockets, and it keeps clothes clean — and enables the doctor to be recognised easily by patients and hospital staff. The majority of patients wished to know the name of the doctor attending to them, hence their preference, like European and Americans, for doctors wearing name plates.[9-11]

We may be criticised for not directly evaluating the acceptability of an informally dressed doctor wearing a white coat. The study does, however, show that when a white coat was not worn denims, a casual shirt and track shoes were consistently less popular than more formal dress without a white coat. Like European and American patients, our patients do not appear to like doctors to be informally dressed in blue denims and training shoes.[9-11]

Considering the results of this scientific evaluation of what was an empirically derived University of Pretoria dress code for students performing clinical duties, we will continue to enforce these regulations in our department. It is tempting to extrapolate our findings to include all students performing clinical duties, but we only tested patients in the antenatal obstetric situation. Maybe Hippocrates was correct when he stated that 'The physician must have a worthy appearance; he should look healthy and be well nourished, appropriate to his physique; for most people are of the opinion that those physicians who are not tidy in their own persons cannot look after others well. Further, he must look to the cleanliness of his person; he must wear decent clothes and use perfumes with harmless smell.'


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