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Healthcare Personnel Attire in Non-Operating-Room Settings

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Healthcare personnel (HCP) attire is an aspect of the medical profession steeped in culture and tradition. The role of attire in cross-transmission remains poorly established, and until more definitive information exists priority should be placed on evidence-based measures to prevent healthcare-associated infections (HAIs). This article aims to provide general guidance to the medical community regarding HCP attire outside the operating room. In addition to the initial guidance statement, the article has 3 major components: (1) a review and interpretation of the medical literature regarding (a) perceptions of HCP attire (from both HCP and patients) and (b) evidence for contamination of attire and its potential contribution to cross-transmission; (2) a review of hospital policies related to HCP attire, as submitted by members of the Society for Healthcare Epidemiology of America (SHEA) Guidelines Committee; and (3) a survey of SHEA and SHEA Research Network members that assessed both institutional HCP attire policies and perceptions of HCP attire in the cross-transmission of pathogens. Recommendations for HCP attire should attempt to balance professional appearance, comfort, and practicality with the potential role of apparel in the cross-transmission of pathogens. Although the optimal choice of HCP attire for inpatient care remains undefined, we provide recommendations on the use of white coats, neckties, footwear, the bare-below-the-elbows strategy, and laundering. Institutions considering these optional measures should introduce them with a well-organized communication and education effort directed at both HCP and patients. Appropriately designed studies are needed to better define the relationship between HCP attire and HAIs.

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Healthcare personnel (HCP) attire is an aspect of the medical profession steeped in culture and tradition. From Hippocrates's admonition that physicians' dress is essential to their dignity, to the advent of nurses' uniforms under the leadership of Florence Nightingale, to the white coat ceremonies that continue to this day in medical schools, HCP apparel and appearance is associated with significant symbolism and professionalism. Recent years, however, have seen a rising awareness of the potential role of fomites in the hospital environment in the transmission of healthcare-associated microorganisms. Although studies have demonstrated contamination of HCP apparel with potential pathogens, the role of clothing in transmission of these microorganisms to patients has not been established. The paucity of evidence has stymied efforts to produce generalizable, evidence-based recommendations, resulting in widely disparate practices and requirements that vary by country, region, culture, facility, and discipline. This document is an effort to analyze the available data, issue reasonable recommendations, and describe the

needs for future studies to close the gaps in knowledge on HCP attire.

INTENDED USE

This document is intended to help acute care hospitals develop or modify policies related to HCP attire. It does not address attire in the operating room (OR), perioperative areas, or other procedural areas and is not intended to guide HCP attire in those settings or in healthcare facilities other than acute care hospitals.

SOCIETY FOR HEALTHCARE EPIDEMIOLOGY OF AMERICA (SHEA) WRITING GROUP

The writing group consists of volunteers among members of the SHEA Guidelines Committee, including those with research expertise on this topic.

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KEY AREAS ADDRESSED

We evaluated and summarized the literature around 2 aspects of HCP attire (details are provided in "Methods"):

- I. Perception of both patients and HCP regarding HCP attire in relation to professionalism and potential risk for transmission of microorganisms.
- II. Evidence for contamination of HCP attire and the potential for HCP attire to contribute to the transmission of pathogenic microorganisms in hospitals.

In addition, we performed a survey of the SHEA membership and SHEA Research Network to learn more about the policies related to HCP attire that are currently in place in members' institutions.

GUIDANCE AND RECOMMENDATION FORMAT

Because this topic lacks the level of evidence required for a more formal guideline using the GRADE system, no grading of the evidence level is provided for individual recommendations. Each guidance statement is based on synthesis of limited evidence, theoretical rationale, practical considerations, a survey of SHEA membership and the SHEA Research Network, author opinion, and consideration of potential harm where applicable. An accompanying rationale is listed alongside each recommendation.

GUIDANCE STATEMENT

There is a paucity of data on the optimal approach to HCP attire in clinical, nonsurgical areas. Attire choices should attempt to balance professional appearance, comfort, and practicality with the potential role of apparel in the cross-transmission of pathogens resulting in healthcare-associated infections (HAIs).

As the SHEA workgroup on HCP attire, we recommend the following:

- I. Appropriately designed studies should be funded and performed to better define the relationship between HCP attire and HAIs.
- II. Until such studies are reported, priority should be placed on evidence-based measures to prevent HAIs (eg, hand hygiene, appropriate device insertion and care, isolation of patients with communicable diseases, environmental disinfection).
- III. The following specific approaches to practice related to HCP attire may be considered by individual facilities; however, in institutions that wish to pursue these practices, measures should be voluntary and accompanied by a well-organized communication and education effort directed at both HCP and patients.
 - A. **"Bare below the elbows" (BBE):** This article defines BBE as HCP's wearing of short sleeves, no wristwatch,

no jewelry, and no ties during clinical practice. Facilities may consider adoption of a BBE approach to inpatient care as an infection prevention adjunct, although the optimal choice of alternate attire, such as scrub uniforms or other short-sleeved personal attire, remains undefined.

1. Rationale: While the incremental infection prevention impact of a BBE approach to inpatient care is unknown, this practice is supported by biological plausibility and studies in laboratory and clinical settings and is unlikely to cause harm.
- B. **White coats:** Facilities that mandate or strongly recommend use of a white coat for professional appearance should institute one or more of the following measures:
 1. HCP engaged in direct patient care (including house staff and students) should possess 2 or more white coats and have access to a convenient and economical means to launder white coats (eg, institution-provided on-site laundering at no cost or low cost).
 - i. Rationale: These practical considerations may help achieve the desired professional appearance yet allow for HCP to maintain a higher frequency of laundering of white coats.
 2. Institutions should provide coat hooks that would allow HCP to remove their white coat (or other long-sleeved outerwear) prior to contact with patients or the patient's immediate environment.
 - i. Rationale: This practical consideration may help achieve the desired professional appearance yet limit patients' direct contact with potentially contaminated attire and avoid potential contamination of white coats that may otherwise be hung on inappropriate objects in the hospital environment.
- C. **Other HCP apparel:** On the basis of the current evidence, we cannot recommend limiting the use of other specific items of HCP apparel (such as neckties).
 1. Rationale: The role played by neckties and other specific items of HCP apparel in the horizontal transmission of pathogens remains undetermined. If neckties are worn, they should be secured by a white coat or other means to prevent them from coming into direct contact with the patient or near-patient environment.
- D. **Laundering:**
 1. **Frequency:** Optimally, any apparel worn at the bedside that comes into contact with the patient or patient environment should be laundered after daily use. In our opinion, white coats worn during patient care should be laundered no less frequently than once a week and when visibly soiled.
 - i. Rationale: White coats worn by HCP who care for very few patients or by HCP who are infrequently involved in direct patient care activities may need to be laundered less frequently than white coats

worn by HCP involved with more frequent patient care. At least weekly laundering may help achieve a balance between microbial burden, visible cleanliness, professional appearance, and resource utilization.

2. **Home laundering:** Whether HCP attire for non-surgical settings should be laundered at home or professionally remains unclear. If laundered at home, a hot-water wash cycle (ideally with bleach) followed by a cycle in the dryer is preferable.

- i. Rationale: A combination of washing at higher temperatures and tumble drying or ironing has been associated with elimination of both pathogenic gram-positive and gram-negative bacteria.

- E. **HCP footwear:** All footwear should have closed toes, low heels, and nonskid soles.

1. Rationale: The choice of HCP footwear should be driven by a concern for HCP safety and should decrease the risk of exposure to blood or other potentially infectious material, sharps injuries, and slipping.

- F. **Identification:** Name tags or identification badges should be clearly visible on all HCP attire for identification purposes.

1. Rationale: Name tags have consistently been identified as a preferred component of HCP attire by patients in several studies, are associated with professional appearance, and are an important component of a hospital's security system.

- IV. Shared equipment, including stethoscopes, should be cleaned between patients.

- V. No guidance can be offered in general regarding prohibiting items like lanyards, identification tags and sleeves, cell phones, pagers, and jewelry, but those items that come into direct contact with the patient or environment should be disinfected, replaced, or eliminated.

METHODS

Using PubMed/Medline, between the months of January and May 2013 we searched the English literature for articles pertaining to HCP attire in clinical settings focusing on areas outside the OR. We included all studies dealing with bacterial contamination and laundering of HCP attire, patients' and providers' perceptions based on the type of attire, and/or HCP footwear.

Additionally, we reviewed and compared hospital policies related to HCP attire from 7 large teaching hospitals, as submitted by members of the SHEA Guidelines Committee. Finally, between February and May 2013 we sent out a survey to all SHEA members to assess their institutional HCP attire policies (if any) and to determine their perceptions of HCP attire as a vehicle for potential transmission of pathogens.

RESULTS

I. Patients' Perceptions of HCP Attire

We identified 26 studies (published from 1990 onward) that examined patients' perceptions of HCP attire¹⁻²⁶ (Table 1). Most (23/26) studies surveyed patient preference for different types of HCP attire^{1-6,8-18,20-25} using either pictures of models in various dress styles^{3,4,7-9,15-18,20,22-24} or descriptions of attire.^{1,5,11,14,21,25} Four studies^{6,10,12,13} asked patients to assess the attire of their actual physicians. Attire descriptions and terminology varied among studies (eg, "formal," "business," "smart," "suit and tie," and "dress") and will be referred to hereafter as "formal attire." We use "casual attire" to refer to anything other than formal attire.

- A. **Formal attire and white coats:** Most of the studies using pictures and models of HCP attire indicated patient preference for formal attire, which was favored over both scrubs^{1,3,7,9,18,22} and casual attire.^{7,9,15,16,19,22} However, several other studies revealed that physician attire was unlikely to influence patients' levels of comfort,^{4,20} satisfaction, trust, or confidence in physicians' abilities,^{2,4,9,19,20,25} even if patients previously had expressed a preference for one type of attire.^{4,9,20,25}

Fifteen studies addressed white coats.^{1,4,7-9,11-17,20-22} In 10 of these studies, patients preferred that physicians wear white coats,^{1,7-10,12,15-17} and in 1 study patients reported feeling more confident in those physicians.⁸ Similarly, 2 studies showed a significant association between the presence of a white coat, especially on a female physician, and patients' trust and willingness to share sensitive information.²² Patients also indicated less comfort in dealing with an informally dressed physician,¹⁶ describing a shirt and a tie as the most professional and desirable attire for physicians²³⁻²⁵ in addition to an overall well-groomed appearance.^{5,15} Moreover, the following items were deemed as inappropriate or undesirable: jeans,^{5,14} shorts,¹⁵ clogs,^{14,15} and open-toed sandals.¹⁵ In the remaining 5 studies, patients showed no clear predilection for one dress style over another or did not consider a white coat either necessary or expected.^{4,11,13,20,21}

Five studies assessed patient satisfaction, confidence, or trust on the basis of their treating physicians' dress,^{2,6,10,12,13} showing little response variations regardless of apparel. A survey of patients seen by obstetricians/gynecologists who were randomly assigned formal attire, casual attire, or scrubs found high satisfaction with physicians regardless of the group allocation.⁶ Similarly, in a before-and-after trial, emergency department (ED) physicians were asked to wear formal attire with a white coat one week followed by scrubs the subsequent week. Using a visual analog scale, patients rated their physician's appearance, professionalism, and satisfaction equally regardless of the week of observation.¹³ Another ED study found no difference in

TABLE 1. Studies of Patient and Healthcare Worker Perception of Healthcare Worker Attire (1990–2012)

Lead author, year (country)	Methodology	Findings
Ardolino, 2009 (UK) ¹	Survey ($n = 100$); Pts Re: Preference for MD attire before/after awareness of BBE policy	Before BBE policy: prefer suit more than WC but WC preferred for junior MD, scrubs not preferred as unprofessional and difficult to distinguish MDs After BBE policy: prefer short-sleeve shirt without tie (older Pts); prefer scrubs (younger Pts)
Baevsky, 1998 (US) ²	Survey ($n = 596$): Urgent care Pts seen by MD in WC and on alternating days, scrubs vs formal attire Re: Satisfaction for courtesy, concern, skill, and likelihood Pt would return/recommend ED	No difference in satisfaction elements for scrubs vs formal attire WC ranked higher when MD broke protocol and did not wear, although when stratified by scrubs vs formal, higher mean ranks for WC noted only when MDs wore scrubs
Bond, 2010 (UK) ³	Survey ($n = 160$): ENT InPts, OutPts Re: Attitudes toward MD attire with photos of male MD in scrubs, formal, and BBE	Attitude, mannerism, and professionalism likely more important than attire Most professional: formal 72%, scrubs 23%, BBE 5% Most hygienic: formal 10%, scrubs 87%, BBE 3% Ease to identify as MD: formal 59%, scrubs 35%, BBE 6% Overall preference: formal 48%, scrubs 41%, BBE 11%
Cha, 2004 (US) ⁴	Survey ($n = 184$): OutPts in predominantly resident-run OB/GYN clinic Re: Preference for MD attire and confidence and comfort with photos of MD in various attire	Attire preference: no preference 60%, WC 38% Pt comfort level: attire does not affect 63% vs does affect 28% Confidence level in MD: attire does not affect 62% vs does affect 24% Mean scores for comfort and confidence levels decreased as attire moved from clinical/formal (scrubs/WC) to casual
Ditchburne, 2006 (UK) ⁵	Survey ($n = 100$): Public in hospital concourse Re: Attitudes to MD not wearing ties	93% did not object to tieless MD, but for staff more likely considered as professional factor Most important: wearing shirt and dress trousers (vs denim), being clean, tidy, formal, wearing clear identifications
Fischer, 2007 (US) ⁶	Survey ($n = 1,136$): Pts and OB/GYN MD before/after randomization of MD attire type Re: Pt satisfaction with MD attire; MDs asked for their preference	Pt satisfaction overall was high and did not change with different MD attire No difference for perceived MD competency and professionalism MD preference: 8 casual, 7 business, 5 scrubs
Gallagher, 2008 (Ireland) ⁷	Survey ($n = 124$): OutPts Re: Preference and ranking of MD attire with photos (formal, casual, WC, scrubs)	Prefer WC, formal, and semiformal vs scrubs and casual WC most preferred; scrubs and casual least preferred
Gherardi, 2009 (UK) ⁸	Survey ($n = 511$): InPts Re: Rated photos of MD in various attire to inspire confidence	WC ranked highest and most confidence inspiring All dress styles rated above neutral except casual (rated lower) Older Pts found scrubs less appealing
Gonzalez del Rey, 1995 (US) ⁹	Survey ($n = 360$): Parents of pediatric ED Pts shown pictures of MD dressed in various types of attire Re: Which doctor would they prefer for their child, does attire matter, do clothes affect trust in MD?	Most preferred attire: formal 44% ($P < .001$) selected for all shifts but less likely selected for Pt seen by night shift Least preferred attire: casual without WC 64% ($P < .001$) Overall, 69% of “most-liked” pictures had WC, and 89% of “least-liked” pictures did not have WC Pictures with scrubs favored by parents with children seen for surgical emergencies Majority did not consider most formally attired as most capable, did not matter how MD dressed and did not influence trust

- Hennessy, 1993 (UK)¹⁰
 Survey ($n = 110$): 2 groups of pre-op Pts, seen by same anesthetist, dressed formal vs casual
 Re: Select adjectives to describe anesthetist/visit, graded 15 dress items as desirable, neutral, or undesirable
- Hueston, 2011 (US)¹¹
 Survey ($n = 423$): OutPts
 Re: Preference for MD attire before/after being informed of possible microbial contamination
- Ikusaka, 1999 (Japan)¹²
 Survey: OutPts seen by groups of MD in WC or private clothes
 Re: Pt tension/satisfaction, preference for MD attire
- Li, 2005 (US)¹³
 Before/after trial ($n = 111$) of Pt opinion in ED
 Re: ED MDs wore WC/formal vs scrubs
- Major, 2005 (US)¹⁴
 Survey ($n = 410$): InPts, surgeons, and public
 Re: Surgeons' attire
- Matsui, 1998 (Canada)¹⁵
 Survey ($n = 220$): OutPt pediatric children/parents
 Re: Asked who they would like as their MD from photos of MD with and without WC; parents also rated attire appropriateness
- McKinstry, 1991 (UK)¹⁶
 Survey ($n = 475$): OutPts in 5 practices
 Re: Pt acceptability for different styles of attire (photos of male and female MDs) for different attire and whether attire influenced their respect for MD
- Mistry, 2009 (UK)¹⁷
 Survey ($n = 200$): Pediatric dental parents/children
 Re: Attitudes on MD attire using photos
- Monkhouse, 2008 (UK)¹⁸
 Survey ($n = 50$): Surgical Pts random survey (ER and elective admits)
 Re: Attitudes toward dress (formal vs scrubs) before/after educational intervention on transmission of microorganisms on ties
- Nair, 2002 (Australia)¹⁹
 Survey ($n = 1,680$): InPts after discharge with crossover trial of MDs in varying attire
 Re: Pt confidence/trust in MD in informal vs "respectable" attire
- No difference between adjective choices (professionalism, approachability) of anesthetist in formal vs casual dress
 Desirability: name tag (90%), WC (66%), polished shoes (62%), short hair (57%), suit (36%) (suit and tie selected more likely desirable if viewed)
 Undesirability: clogs (84%), jeans (70%), trainers (67%), earrings (64%), long hair (62%), open-necked shirt (36%)
 Before education: no clear attire preference but did not favor scrubs (6%), poor agreement with Pt preference and what their MD wears
 After education: decrease preference for WC/tie/formal attire
 Conclusion: attire preferences may change with awareness for contamination
 Tension: WC group 42%, private clothes group 33%
 Satisfaction: no significant difference between attire groups
 WC preference: WC group (older Pts more likely to prefer WC) 71%, private clothes group 39% ($P < .001$)
 No significant difference in scores between 2 dress styles in appearance, satisfaction, or professionalism
 WC necessary: surgeons 72%, InPts 69%, public 42%
 Scrubs appropriate: surgeons 73%, InPts 41%, public 33% ($P < .05$)
 Clogs appropriate: surgeons 63%, InPts 27%, public 18% ($P < .05$)
 Denim appropriate: surgeons 10%, InPts 22%, public 31%
 Selected MD in WC: children 69%, parents 66%
 Most appropriate and favored: name tag, WC, well groomed
 Neutral: scrubs, formal dress
 Not favored: open-toed sandals, clogs, shorts
 Formal dress favored (suit/tie or WC)
 28% would be unhappy seeing one of MDs shown, more likely those dressed informally
 64% thought how their MD dressed was important
 Practice to which a Pt belonged was an independent factor in Pt choice of dress
 WC and mask most popular overall but children favor casual attire
 Formal WC preferred over pediatric coat by parents and children
 Mask preferred over visor (eye contact potentially important)
 Before education: prefer formal for professionalism and approachability; prefer scrubs for hygiene, equal for identifiability; prefer formal dress overall
 After education: prefer scrubs (24% before to 62% after); formal preference decreased (52% before to 22% after)
 Authors' conclusions: if rationale behind modes of surgical dress are explained, Pts are more likely to prefer scrubs to formal clothes
 Pt confidence highest with "respectable" dress
 Loss of WC or tie did not deteriorate confidence significantly
 Informal dress protocol "affront to sensitivities" and presence of nose ring most deleterious

TABLE 1 (Continued)

Lead author, year (country)	Methodology	Findings
Niederhauser, 2009 (US) ²⁰	Survey ($n = 328$): Pts at naval OB/GYN clinic Re: Preference for MD attire and effect on comfort or confidence using pictures	86% neutral whether MD wore a WC 88% said attire did not impact confidence in MD ability Active-duty women were more likely than dependent wives to say MD attire influenced their comfort discussing general/sexual/psychological/personal topics Authors conclude active-duty women may withhold pertinent medical information (eg, personal, sexual history) due to intimidation from military uniform of officer MD
Palazzo, 2010 (UK) ²¹	Survey ($n = 75$): InPts Re: Attitudes of MD attire Randomly chosen medical/surgical InPts rated 6 statements (modal responses provided) and provided reasons for importance of MD dress code; opinions solicited after education of new dress code policy	Aspect of military uniform unique to this study “MD dress important”—strongly agree (reason: dress code instills confidence) “Your MD this admission dressed professionally”—strongly agree “Scrubs are acceptable form of dress”—strongly agree (reason: appears clean) “MD should wear WC”—strongly disagree (reason: sleeves might encourage infection spread, might induce fear and anxiety in Pts) “MD should wear ties”—strongly disagree (reason: unnecessary, uncomfortable) “Is it easy to distinguish between different grades of doctor based on their dress?”—strongly disagree (hard to differentiate MD vs the public) No Pts noticed dress code change prior to being informed of the change All Pts favored dress code change when the suggested impact on infection was explained
Rehman, 2005 (US) ²²	Survey ($n = 400$): Pts/visitors in OutPt clinic Re: Preference, trust, willing to discuss sensitive issues with photos of MDs in various attire	Conclusions: MD attire important but necktie and WC not expected Preferences: professional attire with WC 76%, scrubs 10%, business dress 9%, casual 5% Trust and willing to share sensitive information significantly associated with professional attire ($P < .001$)
Shelton, 2010 (UK) ²³	Survey ($n = 100$): InPts Re: Rate MD attire with photos of male and female MDs before/after being informed of microbial contamination	Female MD dress significantly more important than male MD Before information: no significant difference between most attire except casual dress and short sleeves (considered less appropriate) After information: scrubs and short sleeves considered most appropriate, scrubs preferred for females
Baxter, 2010 (UK) ²⁴	Survey ($n = 480$): InPts Re: Attitudes toward MD attire using photos of male MDs in long sleeves/tie, scrubs, short sleeves	Most professional: long sleeves/tie 77%, scrubs 22%, BBE 1% Greatest transmission risk: long sleeves/tie 30%, scrubs 33%, BBE 37%
Toquero, 2011 (UK) ²⁵	Survey ($n = NA$): orthopedic InPts Re: Awareness/preference for recent BBE policy	Preference for MD attire: long sleeves/tie 63%, scrubs 33%, BBE 4% Unaware of policy: 86% Attire preference: shirt/tie 63%, suits 22%, short sleeve shirt 6%, Pt trust high despite change to less preferred attire
Garvin, 2012 (US) ²⁶	Survey ($n = 1,494$): InPts, MDs, RNs Re: Attitudes toward MD attire	MD appearance important for Pt care: MDs/RNs 93%, InPts 83% ($P < .001$) Concerned with appearance of other provider but did not engage them: MDs 39%, RNs 43%, Pts 16% ($P < .001$) Concerned with appearance of other provider but did not engage them: MDs 39%, RNs 43%, Pts 16% ($P < .001$)

NOTE. BBE, bare below elbows; ED, emergency department; ENT, ear, nose, and throat; InPt, inpatient; MD, physician; NA, not provided; OB/GYN, obstetrics/gynecology; OutPt, outpatient; Pt, patient; RN, nurse; WC, white coat.

patients' satisfaction with the care provided when their physicians wore white coats combined with either scrubs or formal attire.² Similarly, 2 groups of patients who received preoperative care by the same anesthesiologist wearing either formal attire for one group of patients or casual attire for the other found no differences in patient satisfaction between the groups.¹⁰ In contrast, one cross-over trial involving physicians dressed in "respectable" or formal versus "retro" or casual attire found that patient confidence and trust were higher with the respectable-dress protocol.¹⁹ Another study evaluating the attire of patients' treating physicians indicated preference for polished shoes and short hair for men, with jeans, clogs, trainers, and earrings on men being rated as undesirable.¹⁰ A survey among Japanese outpatients indicated a preference for white coats but no significant difference in satisfaction levels based on attire when presented with physicians wearing white coats or "noninstitutional clothes."¹²

- B. **BBE:** Preference for BBE was assessed in 6 studies originating in the United Kingdom following implementation of the nationwide BBE policy^{1,3,23-25} and in 1 US study.¹¹ In these 7 reports, patients did not prefer short sleeves. After informing patients of the BBE policy, older patients were more likely to prefer short-sleeved shirts without ties, while younger patients favored scrubs.¹ After providing information about the potential for cross-contamination from shirt sleeve cuffs and neckties, responses changed from a preference for formal or long-sleeved attire to a preference for short sleeves or scrubs.^{11,18,23} In addition, Shelton et al²³ also found an association between physician gender and BBE attire: after a statement informing the participants of the potential cross-transmission of microorganisms by attire, patients preferred scrubs for female physicians but did not differentiate between scrubs and short-sleeved shirts for male physicians.
- C. **Ties:** Neckties were specifically addressed in several studies from the United Kingdom.^{5,21,24} In one study, patients reported that attire was important but that neckties were not expected.²¹ Similarly, in a survey among individuals in the public concourse of a hospital, 93% had no objection to male physicians not wearing ties.⁵ None of these studies evaluated neckties in the context of patients' perceptions of infection prevention.
- D. **Laundering of clothes:** In one study, patients identified "daily laundered clothing" as the single most important aspect of physicians' appearance.⁸
- E. **Other factors:** Several additional variables may influence patient preference for physician attire, including age of either the patient or the managing physician, gender of the practitioner, time of day, setting, and the attire patients are accustomed to seeing. In Japan, older patients were more likely to prefer white coats.¹² Similarly, older patients in England found scrubs less appealing than did younger patients.⁸ Pediatric dental patients were more likely than

their parents to favor casual attire.¹⁷ Patients preferred formal attire for senior consultants but thought that junior physicians should be less formal.¹ Patients identified female physicians' attire as more important than the attire worn by male physicians.²² Formal attire was less desirable by patients seen during the night shift.⁹ Parents of children being seen in the ED favored surgical scrubs. Additionally, 2 trials evaluated attire preference on the basis of what patients often see their HCP wearing. In one trial, patients accustomed to seeing their anesthesiologist in a suit were more likely to find suits and ties desirable.¹⁰ Similarly, the practice to which a patient belonged was found to be an independent factor in the patient's choice of preferred attire;¹⁶ however, another study found poor agreement between patient preferences and their physicians' typical attire.¹¹

In summary, patients express preferences for certain types of attire, with most studies indicating a predilection for formal attire, including a white coat, but these partialities had a limited overall impact on patient satisfaction and confidence in practitioners. This is particularly true in trials that evaluated the effect of attire on patient satisfaction in real-world settings. Patients generally do not perceive white coats, formal attire, or neckties as posing infection risks; however, when informed of potential risks associated with certain types of attire, patients appear willing to change their preferences for physician attire.^{11,18}

II. HCP Perceptions regarding Attire

Few studies evaluated HCP preferences with regard to attire.^{5,6,14,26} While most studies addressed specific elements of HCP attire, one looked at the overall importance of attire and found that 93% of physicians and nurses versus 83% of patients thought that physician appearance was important for patient care ($P < .001$).²⁶

- A. **White coats:** In a survey exploring perceptions of surgeons' apparel performed among surgeons themselves, inpatients, and the nonhospitalized public, all 3 groups were equally likely to consider a white coat necessary and blue jeans inappropriate. Surgeons were more prone to consider scrubs and clogs appropriate.¹⁴ In another survey of 15 obstetricians/gynecologists, 8 preferred casual attire, while 7 preferred formal attire.⁶ Three studies assessed HCP alongside patient perception of infection risk or lack of hygiene associated with white coats, formal attire, or neckties,^{3,24,26} with one finding that HCP were more likely than patients to consider white coats unhygienic.²⁶
- B. **Ties:** In a survey performed in a public concourse of a UK hospital, HCP were more likely than non-HCP to prefer physicians' wearing of neckties for reasons of professionalism.⁵
- C. **Laundering of clothes:** A recent survey showed that non-surgical providers preferentially (and without prompting)

laundered their scrubs every 1.7 ± 0.1 days (mean \pm standard error) compared with white coats, which were laundered every 12.4 ± 1.1 days ($P < .001$); however, the reasons for this divergent behavior remain unclear.²⁷

III. Studies of Microbial Contamination of Apparel in Clinical and Laboratory Settings

No clinical studies have demonstrated cross-transmission of healthcare-associated pathogens from a HCP to a patient via apparel; however, a number of small prospective trials have demonstrated the contamination of HCP apparel with a variety of pathogens (Table 2).^{5,28-37}

A. White coats/uniforms: The 5 studies we evaluated indicate that physician white coats and nursing uniforms may serve as potential sources of colonization and cross-transmission. Several studies described contamination of apparel with *Staphylococcus aureus* in the range of 5% to 29%.^{30,33-35,38} Although gram-negative bacilli have also been identified, these were for the most part of low pathogenicity;^{30,35} however, actual pathogens, such as *Acinetobacter* species, Enterobacteriaceae, and *Pseudomonas* species, have been reported.³⁸

A number of factors were found to influence the magnitude of contamination of white coats and uniforms. First, the degree of contamination was correlated with more frequent usage of the coat,³⁵ recent work in the inpatient setting,³⁴ and sampling certain parts of the uniform. Higher bacterial loads were found on areas of clothing that were more likely to come into contact with the patient, such as the sleeve.³⁵ Additionally, the burden of resistant pathogens on apparel was inversely correlated with the frequency of lab coat change.³⁸ Apparel contamination with pathogenic microorganisms increased over the course of a single patient care shift. Burden et al²⁸ demonstrated that clean uniforms become contaminated within only a few hours of donning them. Similarly, a study testing nurses' uniforms at both the beginning and the end of their shifts described an increase in the number of uniforms contaminated with one or more microorganisms from 39% to 54%, respectively. The proportion of uniforms contaminated with vancomycin-resistant enterococci (VRE), methicillin-resistant *S. aureus* (MRSA), and *Clostridium difficile* was also noted to increase with shift work.³³

In the first report of a positive correlation between contamination of hands and contamination of white coats, Munoz-Price et al³⁹ cultured the hands, scrubs, and white coats of intensive care unit staff. The majority of bacteria isolated from hands were skin commensals, but HCP were also found to have contamination of hands, scrubs, and white coats with potentially pathogenic bacteria, including *S. aureus*, *Enterococcus* species, and *Acinetobacter baumannii*. Among dominant hands, 17% of 119 hands were

contaminated with one of these species, and staff members with contaminated hands were more likely to wear a white coat contaminated with the same pathogen. This association was not observed with scrubs.

B. BBE: Two observational trials evaluated the bacterial contamination of HCP's hands on the basis of BBE attire versus controls, finding no difference in total bacterial counts or in the number of clinically significant pathogens.^{40,41} In contrast, Farrington et al,⁴² using a fluorescent method, examined the efficacy of an alcohol hand wash among BBE providers versus controls. The authors found decreased efficacy of hand hygiene at the wrist level in the non-BBE group, suggesting that the BBE approach may improve wrist disinfection during hand washing.

The United Kingdom has adopted a BBE approach, on the basis of the theory that it will limit patient contact with contaminated HCP apparel and to promote better hand and wrist hygiene. However, a randomized trial comparing bacterial contamination of white coats against BBE found no difference in total bacterial or MRSA counts (on either the apparel itself or from the volar surface of the wrist) at the end of an 8-hour workday.²⁸

C. Scrubs: The use of antimicrobial-impregnated scrubs has been evaluated as a possible solution to uniform contamination. In a prospective, randomized crossover trial of 30 HCP in the intensive care unit setting,³⁶ when compared with standard scrubs, antimicrobial-impregnated scrubs were associated with a 4–7 mean log reduction in surface MRSA burden, although there was no difference in MRSA load on HCP hands or in the number of VRE or gram-negative bacilli cultured from the scrubs. The study did not assess the HAI impact of the antimicrobial scrubs.

D. Ties: Several studies indicated that neckties may be colonized with pathogenic bacteria, including *S. aureus*. Lopez et al³¹ reported a significantly higher bacterial burden on neckties than on the front shirt pocket of the same subject. In 3 studies, up to 32% of physician neckties grew *S. aureus*.^{5,31,37} Steinlechner et al³⁷ identified additional potential pathogens and commensals from necktie cultures, including *Bacillus* species and gram-negative bacilli. Two reports found that up to 70% of physicians admitted having never cleaned their ties.^{5,31}

E. Laundering of clothes: Numerous articles published during the past 25 years describe the efficacy of laundering hospital linens and HCP clothing,⁴⁴ but most investigations of the laundering of HCP attire have employed in vitro experimental designs that may or may not reflect real-life conditions. A 2006 study⁴⁵ demonstrated that while clothes lost their burden of *S. aureus*, they concomitantly acquired oxidase-positive gram-negative bacilli in the home washing machine. These bacteria were nearly eliminated by tumble drying or ironing. Similarly, investigators found that recently laundered clothing material acquired gram-negative bacteria from the washing ma-

chine, which were subsequently eliminated by ironing. Another in vitro study in the United Kingdom compared the reduction of microorganisms on artificially inoculated nurses' uniform material after washing at various temperatures as well as with and without detergents. Washing uniforms contaminated with MRSA and *Acinetobacter* species at a temperature of 60°C, with or without detergent, achieved at least a 7-log reduction in the bacterial burden of both microorganisms.⁴⁶ There is no robust evidence that centralized industrial laundering decontaminates clothing more effectively than home laundering.⁴³

- F. **Footwear:** Although restrictions on HCP footwear are influenced by a desire to meet patients' preferences for appropriate attire,^{10,14,15} most are driven by concerns for HCP safety.⁴⁷⁻⁵⁰ Studies have found that wearing of shoes with closed toes, low heels, and nonskid soles can decrease the risk of exposure to blood or other potentially infectious material,^{47,48,50,51} sharps injuries,^{48,50,52} slipping,⁵⁰ and musculoskeletal disorders.⁴⁹

Casual, open footwear, such as sandals, clogs, and foam clogs, potentially expose feet to injury from dropped contaminated sharps and exposure to chemicals in healthcare facilities. A comparison of needlestick injury surveillance data from the standardized Exposure Prevention Information Network program revealed a higher proportion of hollow-bore needle injuries to the feet of Japanese HCP, with 1.5% of 16,154 total injuries compared with 0.6% of 9,457 total injuries for US HCP (2.5 times higher; $P < .001$).⁴⁸ Although multiple factors were linked to these injuries, one included the common practice in Japan to remove outdoor shoes and replace them with open-toed slippers on hospital entry.

Footwear is an area of increased concern in the OR. The Association of periOperative Registered Nurses (AORN) recommends that OR footwear have closed toes as well as backs, low heels, and nonskid soles to prevent slipping.⁵⁰ The US Occupational Safety and Health Administration (OSHA) requires the use of protective shoes in areas where there is a danger of foot injuries from falling objects or objects piercing the soles.⁴⁷ One study that measured the resistance of shoes to penetration by scalpels showed that of the 15 pairs of shoes studied, only 6 were made of material that was sharp resistant, including sneaker suede, suede with inner mesh lining, leather with inner canvas lining, nonpliable leather, rubber with inner leather lining, and thicker rubber.⁵² The OSHA bloodborne pathogens standard mandates that employers determine the workplace settings in which gross contamination with blood or body fluids is expected, such as the OR, and to provide protective shoe coverings in those settings.^{47,48,50,51} Shoe covers are not meant to prevent transmission of bacteria from the OR floor; in fact, preliminary data show that the OR floor may play a dynamic role in the horizontal transmission of bacteria due to frequent floor contact of objects that then directly touch the patient's body (eg,

intravenous tubing, electrocardiogram leads).⁵³

When HCP safety concerns or patient preference conflict with a HCP's desire for fashion, a facility's dress code can be the arbiter of footwear. OSHA allows employers to make such dress code determinations without regard to a worker's potential exposure to blood, other potentially infectious materials, or other recognized hazards.

IV. Outbreaks Linked to HCP Apparel

Wright et al⁵⁴ reported an outbreak of *Gordonia* potentially linked to HCP apparel. In this report, postoperative sternal wound infections with *Gordonia bronchialis* in 3 patients were linked to a nurse anesthetist. *Gordonia* was isolated from the HCP's scrubs, axillae, hands, and purse and from multiple sites on the HCP's roommate.

V. Studies from Developing Countries

In Nigeria, factors identified increasing the likelihood of bacterial contamination of white coats included daily laundering and use limited to patient care rather than nonclinical duties.⁵⁵ In India,⁵⁶ medical students' white coats were assessed for bacterial contamination, paired with surveys about laundering habits and attitudes toward white coats. Coats were contaminated most frequently with *S. aureus*, followed by *Pseudomonas* species and coagulase-negative staphylococci. A similar trial of white coats used by staff in a rural dental clinic also revealed predominantly gram-positive contamination.⁵⁷

VI. Hospital Policies Addressing HCP Attire

We reviewed and compared policies related to HCP attire from 7 large teaching hospitals or health systems. In general, policies could be categorized into 2 groups:

- A. General appearance and dress of all employees
- B. Standards for HCP working in sterile or procedure-based environments (OR, central processing, procedure areas, etc)

Policies were evaluated for the following elements:

- A. Recommended clothing (eg, requirement for white coats, designated uniforms) or other options (eg, BBE)
- B. Guidance regarding scrubs
- C. Use of name tags
- D. Wearing of ties
- E. Requirements for laundering or change of clothing
- F. Footwear and nonapparel items worn or carried by HCP
- G. Personal protective equipment

All institutions' human resources policies outlined general appearance or dress code requirements for professional standards of business attire; however, institutions varied in job-specific policies and for the most part did not address more specific attire requirements except for OR-related activities. Few institutional policies included enforcement provisions. The institutions that required accountability varied from de-

TABLE 2. Apparel and Microbial Burden: Review of Studies in Laboratory and Clinical Settings

Lead author, year	Methodology	Findings
Bearman, 2012 ³⁶	Prospective crossover trial of HCWs in ICU ($n = 30$) Randomized to antimicrobial vs control scrubs Samples obtained from scrub abdominal area, pocket, and hands weekly	HCW scrubs colonized during course of Pt care with MRSA Antimicrobial scrubs associated with a 4–7 mean log reduction in MRSA but not VRE or GNR No differences in bacterial hand burden or in HCWs with unique positive scrub cultures No data reported on cross-transmission to Pts
Burden, 2011 ²⁸	Randomized trial comparing contamination on regular (dirty) WC vs short-sleeved UK-style MD uniform laundered daily	No significant difference in bacterial burden between dirty WCs and recently washed uniforms; clean uniforms contaminated within few hours of donning No information on frequency WCs were washed or hand hygiene rates Suggests no microbiological advantage of BBE No significant difference in bacterial counts (many skin commensals, no MRSA) between groups
Burger, 2011 ⁴⁰	Prospective observational study ($n = 66$) MDs from multiple specialties (38 BBE, 28 were not) volunteered without notice during normal work day Agar imprints of fingers, palms, wrists, and forearms, repeated after hand hygiene; imprints of cuffs of those not BBE	Some MDs had higher counts after HH Large variation in number of colonies cultured Authors conclude “no difference in density or type of baseline flora on hands and forearms irrespective of dress code”
Ditchburne, 2006 ⁵	MD ties cultured ($n = 40$)	HH reduced colony counts from fingertips, palms, and wrists in all groups MD ties capable of carrying bacteria, including MRSA: 40% of ties grew MSSA (1 with MRSA) 70% had never laundered tie 93% had no objection to not wearing ties Authors suggest substitute other attire for ties to preserve professional image
Farrington, 2009 ⁴²	BBE vs non-BBE randomized trial of MD ($n = 58$) and medical students ($n = 61$) at a 900-bed teaching hospital Participants cleaned hands using alcohol, with areas fluorescing by UV light considered “missed” and recorded on a standard hand diagram	No data reported on cross-transmission to Pts No significant difference found between 2 groups in percentage area of hands missed The non-BBE group missed more wrist vs BBE group ($P < .002$) Mean percent area missed on wrists significantly higher than hands in both groups ($P < .001$) Strengths: high participation rate without dropouts, single investigator created hand diagrams
Gaspard, 2008 ²⁹	Descriptive study of staff clothing in 3 LTCFs Uniforms ($n = 256$) from 90 RNs, 166 care partners sampled from waist zone pocket and between pockets	Weaknesses: Hawthorne effect Author conclusions: BBE did not affect quality of HH, and although BBE improved wrist washing, the clinical significance is uncertain HCW apparel frequently contaminated with MRSA 27%–80% MRSA recovery from “waist zone”; 18%–60% MRSA recovery from “pocket zone” Authors stressed HH to limit cross-transmission from apparel to Pts via HCW hands No data reported on cross-transmission to Pts

Jacob, 2007 ⁴³	Department of Health Working Group on Uniforms and Laundry: evidence-based document on wearing and laundering uniforms from 2 literature reviews (Thames Valley University and University College London Hospital NHS Trust) Examined role of uniforms in infection transfer, efficacy of laundry practices in removing contamination, how uniforms affect image of individual and organizations	No conclusive evidence that uniforms pose a significant hazard to spread infection Public does not like seeing hospital staff in uniform outside workplace All components of properly designed and operated laundering help to remove/kill microorganisms on fabric Ten-minute wash at 60°C sufficient to remove most microorganisms Detergents can remove many microorganisms from fabrics at lower temperature (eg, MRSA removed at 30°C) No conclusive evidence for difference between commercial or domestic laundering to remove microorganisms
Loh, 2000 ³⁰	Random sample ($n = 100$) Cultured medical students' WCs	Authors provide list of good (and poor) practice examples with reasons: • Good practice example: "Dress in a manner which is likely to inspire public confidence" • Poor practice example: "Wear false nails for Pt care" MSSA recovered from back, pocket, and sleeves Students report occasional or infrequent WC laundering Authors suggest hospitals provide laundered WCs for students
Lopez, 2009 ³¹	Sampled shirts/ties from internists/surgeons ($n = 25/25$) for paired bacterial counts	No data reported on cross-transmission to Pts 16 participants had never cleaned their tie; 20 participants could not remember when tie last cleaned
Morgan, 2012 ³²	Cohort study of sequential HCW interaction with Pts with culture of gowns/hands linked to environmental cultures	Bacterial counts from ties significantly higher than those paired from shirts Significant fraction of physicians (16) had <i>Staphylococcus aureus</i> isolated from clothes Apparel infrequently laundered (ties) associated with higher bacterial burden No data reported on cross-transmission to Pts Study with PFGE linking environmental isolates, gowns/gloves, and Pts in >80% of cases (<i>Acinetobacter</i> , MDR <i>Pseudomonas</i> , MRSA) Contamination of gowns/gloves during care of MDRO Pts most frequent with <i>A. baumannii</i>
Perry, 2001 ³³	Cross-sectional sample ($n = 57$) Bacterial contamination across 5 services Sampled belt area—hem at start vs end of shift	Environmental contamination major determinant of transmission to HCW gloves/gowns Environmental cultures related to gowns/gloves more than clothing MRSA, VRE, and <i>Clostridium difficile</i> recovered Bacterial contamination of hospital-supplied apparel present at start of shift and increased by end of shift: • Start shift: 39% of uniforms positive with ≥ 1 microorganism • End shift: 54% of uniforms positive with ≥ 1 microorganism All uniforms laundered at home
Scott, 1990 ³⁸	In vitro experiment: bacterial transfer from laminate surfaces and cloths to hands	No data reported on cross-transmission to Pts Contaminated inanimate surfaces (eg, laminates, textiles) associated with bacterial transfer to fingers: <i>Escherichia coli</i> , <i>Salmonella</i> species, MSSA
Steinlechner, 2002 ³⁷	Cohort of orthopedic surgeons ($n = 26$) Sampled ties for bacterial growth	295 bacterial isolates: 45% were <i>Bacillus cereus</i> , CNS, GNRs, <i>S. aureus</i> No data reported on cross-transmission to Pts

TABLE 2 (Continued)

Lead author, year	Methodology	Findings
Treake, 2009 ³⁴	Cross-sectional study Attendees ($n = 149$) of medical and surgical grand rounds at a large teaching hospital Sampled WCs for growth	34 (23%) WCs grew <i>S. aureus</i> ; 6 (18%) were MRSA No VRE recovered Large fraction of HCP WCs contaminated with <i>S. aureus</i> , including MRSA WCs may be vectors of <i>S. aureus</i> transmission No data reported on cross-transmission to Pts Nearly all HCW clothing heavily contaminated with skin flora, 63% with potential pathogens (<i>Acinetobacter</i> species, <i>S. aureus</i> , Enterobacteriaceae) No data reported on cross-transmission to Pts No significant difference in either CFU or pathogens in BBE vs no BBE No MDRO cultured from MD hands Participants not given an opportunity for hand hygiene prior to enrollment Study does not identify group for the 50% of MDs who wore uniforms with antibacterial properties Authors concluded that BBE per se does not have impact on degree of contamination on MD hands and BBE initiative should not divert from other important measures, such as hand hygiene, appropriate Pt: RN ratios HCW uniforms and WCs can become progressively contaminated with bacteria of low pathogenicity (from HCWs) and mixed pathogenicity (from environment) Data do not support role of apparel as vehicles for cross-transmission 25% MSSA contamination of WCs for both physicians and surgeons (cuffs, pockets) Degree of contamination associated with increased frequency of WC usage No data reported on cross-transmission to Pts Same species in RN anesthetist, her clothing, her roommate, and her roommate's clothing; home laundering of scrubs implicated (but not confirmed) as origin of staff clothing colonization Reminder that home laundering scrubs can be problematic
Wiener-Well, 2011 ³⁸	Cross-sectional convenience sample of MDs/RNs ($n = 135$) with survey and cultures of uniforms/WC	
Willis-Owen, 2010 ⁴¹	Prospective, cross-sectional, observational study ($n = 92$) Agar imprints of MD hands from multiple specialties during normal work day (49 BBE, 43 not) No. of CFU graded light (<10), moderate (10–20), or heavy (>20) with presence of pathogens recorded	
Wilson, 2007 ³⁹	Systematic review of published literature	
Wong, 1991 ³⁵	Cross-sectional survey Bacterial contamination of WCs in a British hospital	
Wright, 2012 ³⁴	Outbreak report Cluster of 3 Pts with deep sternal wound infections due to <i>Gordonia</i> species	

NOTE. BBE, bare below elbows; CNS, coagulase-negative staphylococci; GNR, gram-negative rod; HAI, healthcare-associated infection; HCP, healthcare personnel; HCW, healthcare worker; HH, hand hygiene; ICU, intensive care unit; InPt, inpatient; LTICF, long-term care facility; MD, physician; MDR, multidrug resistant; MDRO, multidrug-resistant organism; MRSA, methicillin-resistant *Staphylococcus aureus*; MSSA, methicillin-susceptible *S. aureus*; NHS, National Health Service; OutPt, outpatient; PFGE, pulsed-field gel electrophoresis; Pt, patient; RN, nurse; VRE, vancomycin-resistant enterococci; WC, white coat.

tailoring the supervisor's administrative responsibilities to more specific consequences for employee noncompliance.

Three institutions recommended clothing (such as color-coded attire) for specific types of caregivers (eg, nurses, nurses' assistants, etc). Policies specific to clinical personnel were most frequently related to surgical attire, including scrubs, use of masks, head covers, and footwear in restricted and semirestricted areas and surgical suites, and to central processing, as consistent with AORN standards. Scrubs were universally provided by the hospital in these settings. Laundering policies clearly indicated that laundering of hospital-provided scrubs was to be performed by the hospital or at a hospital-accredited facility. Use of masks, head covers, footwear, and jewelry were generally consistent with AORN standards.

Excluding surgical attire, only one institution provided guidance specific to physicians, outlining a recommendation for BBE attire during patient care. This policy specified not to use white coats, neckties, long sleeves, wristwatches, or bracelets. Institutional policies also varied in recommendations for laundering and change of clothing other than for surgical attire. No specific guidance was issued for other uniforms, other than cleanliness and absence of visible soiling; however, one institution referred to infection control specifications for maintenance of clothing. Guidance regarding frequency of clothing change was variable for scrubs, from nonspecific requirements (eg, wearing freshly laundered surgical attire on entry to restricted/semirestricted areas) to specific requirements (clean scrubs once per shift to once daily and if visibly soiled). In addition, most policies included instructions for HCP to remove scrubs and change into street clothes either at the end of the shift or when leaving the hospital or connected buildings.

VII. Survey Results

A total of 337 SHEA members and members of the SHEA Research Network (21.7% response of 1,550 members) responded to the survey regarding their institutions' policies for HCP attire. The majority of respondents worked at hospitals (91%); additional facilities included freestanding children's hospitals (4%), freestanding clinics (1%), and other facility types (5%), such as long-term acute care hospitals, multihospital systems, short-term nursing facilities, and rehabilitation hospitals (rounding of numbers accounts for the sum of percentages being greater than 100). The majority of responses were from either university/teaching hospitals (39%) or university/teaching-affiliated hospitals (28%). We received additional responses from nonteaching hospitals (24%), Veterans Affairs hospitals (3%), specialty hospitals (2%), and miscellaneous facilities (4%).

Enforcement of HCP attire policies was low at 11%. A majority of respondents (65%) felt that the role of HCP attire in the transmission of pathogens within the healthcare setting was very important or somewhat important.

Only 12% of facilities encouraged short sleeves, and 7% enforced or monitored this policy. Pertaining to white coats, only 5% discouraged their use and, of those that did, 13% enforced or monitored this policy. For watches and jewelry, 20% of facilities had a policy encouraging their removal. A majority of respondents (61%) stated that their facility did not have policies regarding scrubs, scrub-like uniforms, or white coats in nonclinical areas. Thirty-one percent responded that their hospital policy stated that scrubs must be removed before leaving the hospital, while 13% stated that scrubs should not be worn in nonclinical areas. Neckties were discouraged in 8% of facilities, but none monitored or enforced this policy.

Although 43% of respondents stated that their hospitals issued scrubs or uniforms, only 36% of facilities actually laundered scrubs or uniforms. A small number of hospitals provided any type of guidance on home laundering: 13% provided specific policies regarding home laundering, while 38% did not.

In contrast to other items of HCP attire, half of facilities required specific types of footwear, and 63% enforced and/or monitored this policy.

DISCUSSION

Overall, patients express preferences for certain types of attire, with most surveys indicating a preference for formal attire, including a preference for a white coat. However, patient comfort, satisfaction, trust, and confidence in their physicians is unlikely to be affected by the practitioner's attire choice. The ability to identify a HCP was consistently reported as one of the most important attributes of HCP attire in studies. This was particularly true in studies that evaluated the effect of attire of actual physicians on patient satisfaction in a real-world setting rather than those assessing the influence of physician attire on patient satisfaction in the abstract. Patients generally did not perceive white coats, formal attire, or ties as posing infection risks; however, when informed of potential risks associated with certain types of attire, patients were willing to change their preferences for physician attire.^{11,18}

Data from convenience-sample surveys and prospective studies confirm that contamination occurs for all types of HCP apparel, including scrubs, neckties, and white coats, with pathogens such as *S. aureus*, MRSA, VRE, and gram-negative bacilli. HCP apparel can hypothetically serve as a vector for pathogen cross-transmission in healthcare settings; however, no clinical data yet exist to define the impact of HCP apparel on transmission. The benefit of institutional laundering of HCP scrubs versus home laundering for non-OR use remains unproven. A BBE approach is in effect in the United Kingdom for inpatient care; this strategy may enhance hand hygiene to the level of the wrist, but its impact on HAI rates remains unknown.

Hospital policies regarding HCP attire were generally consistent in their approach to surgical attire; however, general

dress code policies varied from guidance regarding formal attire to use of job-specific uniforms. Laundering and change of clothing was also not consistently addressed other than for surgical attire. Finally, accountability for compliance with the attire policies by HCP and supervisors was not routinely included in the policies.

AREAS FOR FUTURE RESEARCH

- I. Determine the role played by HCP attire in the horizontal transmission of nosocomial pathogens and its impact on the burden of HAIs.
- II. Evaluate the impact of antimicrobial fabrics on the bacterial burden of HCP attire, horizontal transmission of pathogens, and HAIs. Concomitantly, a cost-benefit analysis should be conducted to determine the financial merit of this approach.
- III. Establish the effect of a BBE policy on both the horizontal transmission of nosocomial pathogens and the incidence of HAIs.
- IV. Explore the behavioral determinants of laundering practices among HCP regarding different apparel and examine potential interventions to decrease barriers and improve compliance with laundering.
- V. Examine the impact of not wearing white coats on patients' and colleagues' perceptions of professionalism on the basis of HCP variables (eg, gender, age).
- VI. Evaluate the impact of compliance with hand hygiene and standard precautions on contamination of HCP apparel.

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