Put your ties back on

Informal dress among doctors may be an unexpected side effect of a ban on ties in the United Kingdom. But, asks **Stephanie Dancer**, does this scruffiness also reveal something about how we view hygiene today?

Not long ago an article in the *Daily Mail* commented unfavourably on so called scruffy doctors.[1] The fashion for dressing down in the United Kingdom is a consequence of the Department of Health's edict in 2007 that in the interest of hospital hygiene doctors should not wear ties.[2]

Now many junior doctors have abandoned formal wear in favour of T shirts and the like. I hear that patients complain that they do not know who the doctor is: no tie, no white coat, no jacket, and no presence. Doctors are members of a distinguished profession and should dress accordingly. Untidiness erodes the image of doctors as responsible and competent.[3]

Is there any evidence that staff apparel has been implicated in the transmission of pathogens to patients? None at present, although all clothes, including ties, may be covered with a range of microbial flora.[4 5] Hand touch contact, airborne delivery, environmental reservoirs, and human carriage are all implicated in transmission. Given that bed linen and pyjamas are habitually contaminated with their owners' personal microbial flora, the focus on transmission from what staff are wearing seems disproportionate and perhaps even irrelevant.[6]

Of course, scruffiness among doctors could also indicate something more sinister. Scruffiness is synonymous with being untidy, dishevelled, and unkempt, with having straggly hair, ill fitting clothes, and scuffed shoes—or trainers—as well as not wearing a tie and so on. Together these might be taken as a flashing neon sign that says "I don't care." Scruffiness, however defined, also intimates a lack of personal hygiene and correspondingly lower standards of hygienic behaviour. Personal habits such as scratching your hair or nose with your fingers contribute towards contamination of the next item or patient that you touch. Wearing the same clothes for several days showers the environment with millions of skin organisms, not all of them friendly. It could be argued that ditching the white coat and tie for hygiene purposes has had the converse effect, in that the informal attire now gracing our wards has encouraged a less robust view of infection control.

Maybe junior doctors do not understand the real meaning of cleanliness. Easy access to antibiotics has eroded the importance of basic hygiene over the past half century.[7] Consider the monumental efforts required to entice us to clean our hands, for example.[8] Similarly, recent public furore over so called "dirty" hospitals culminated in a costly deep clean for English hospitals.[9] Was it like this before antibiotics? Twenty first century hospitals are congested and understaffed, with poor ventilation and stuffy wards.[10] Hygiene is no longer appreciated as a key tool against infection, although politicians and professionals make sure that it is prodigiously mentioned in any new mandate targeting hospital acquired infections. Given that cleanliness is no longer a matter of life or death, it is no wonder our junior doctors dress the way they do.

Given that bed linen and pyjamas are habitually contaminated with their owners' personal microbial flora, the focus on transmission from what staff are wearing seems disproportionate and perhaps even irrelevant

Are medical students being made aware of the almost inevitable demise of the antimicrobial era? I suspect that students, and other healthcare trainees, are unlikely to receive any mention of hygiene principles, let alone a lecture on its escalating importance.[11] The science of dirt removal might lack the excitement of the newer disciplines of interventional radiology or nanoparticles, yet, given the future challenges of fighting infection, surely some education on hygiene might be permitted to rise, like a phoenix, from the ashes of all those squandered antibiotics.

The lack of the tie is not just a visual wave in the direction of infection control. Nor is it another tick in a box on the audit clipboard. "No tie"—along with stubble, spitting, picking your nose, and gravity defying trousers—symbolises the real status of hygiene in today's society.[12]

The dress code for UK doctors was imposed more as a political gesture than as an evidence based strategy likely to reduce infections acquired in hospitals.[6-14] In contrast, long term investment in traditional hygiene strategies would reap dividends.[13] Before the antibiotics run out we need to revisit the hygiene values of the past and we need to communicate those values to the doctors of the future.[7 11 15]

Common sense often turns into scientific evidence at some stage; you just have to wait for it.[7] How about a bow tie, gentlemen?[16]

Stephanie J Dancer is a consultant microbiologist, Hairmyres Hospital, East Kilbride, Lanarkshire
stephanie.dancer@lanarkshire.scot.nhs.uk

I thank Alasdair Geddes, emeritus professor of infectious diseases at the University of Birmingham, who insisted on and inspired the writing of this article.

Competing interests: As a woman I don't wear a tie.

Provenance and peer review: Not commissioned, not externally peer reviewed.

References are in the version on bmj.com.

Cite this as: *BMJ* 2013;346:f3211

bmj.com/blogs

Andrew Burd: Bring back the white coat

Rapid responses on bmj.com

"Forget about ties: giving up white coats was the single greatest wardrobe related contributing factor to loss of status of and respect for hospital doctors."
Jeremy Fletcher, consultant physician, Mid-Essex Hospitals, Chelmsford

"I have worn a tie as part of medical dress for over 30 years and am suspicious about the quality of evidence against them. It does, however, seem to me that junior doctors and medical students, whatever their dress, are even more careful than their senior colleagues about hand washing."
Tim Harlow, palliative care physician, Hospiscare

"I have been wearing a bow tie ever since the government banned hospital doctors from wearing white coats . . . which was based on flawed evidence . . . I urge my male colleagues to don a bow tie. Patients will know who's who, even from a distance, and I doubt if anyone will describe us any longer as scruffy."
Adam Magos, consultant gynaecologist, Royal Free Hospital, London

FROM THE FRONTLINE **Des Spence**

End the scandal of free medical education

Gullibility is a flaw in medicine, because our job is to give patients what they need, not what they want. Doctors believe their intelligence protects them from pharma marketing but are in complete denial. Doctors follow the herd and are in thrall to the mob.

Big pharma spent £40m last year supporting "educational activity" for health professionals.[1] Why? Because sponsored education is just marketing masquerading as education, with the sole aim to influence doctors. Doctors are conditioned to be deferential and follow orders. So pharma exploits this weakness. It pays hard cash to omniscient and omnipresent preaching specialists. Local consultants are influential, but the international specialist is medicine's infallible pontiff. And the gravitas of a specialist is measured in research publications, and these in turn are in the gift of big pharma. Many of medicine's world opinion leaders were anointed by pharma. Experts publish in leading journals, talk on the television, advise governments, work for charities, and sit on international guideline groups.

Big pharma still provides international travel, accommodation, and hospitality to NHS doctors, all hidden from public scrutiny, and this is unacceptable

Twitter
Follow Des Spence on Twitter @des_spence1

At a local level, pharma education is about getting access to doctors and establishing personal relationships with pharmaceutical representatives. Big pharma still provides international travel, accommodation, and hospitality to NHS doctors, all hidden from public scrutiny, and this is unacceptable.

The world is changing, and education is moving online. Big pharma is on the case, offering free continuing medical education created by third parties, such as sponsored BMJ Learning modules.[2]

But these independent third parties may become dependent on big pharma's financial support, which will potentially erode independence. Educational sponsorship is about controlling the medical agenda and endorsing a blind therapeutic mindset. It is free medical education sponsored by the industry that has helped spawn overtreatment, polypharmacy, medicalisation, and high costs.

What if pharma didn't provide education? Radically, doctors could pay for education themselves. We might think twice about jetting off to Florida if we paid personally. Alternatively, education could be provided through easy, cheap and cheerful online modules, forums, and lectures commissioned by the NHS. We should have more small local groups for self directed learning.

What are the potential levers to change this educational dependence? Firstly, the royal colleges should stop approving continuing medical education from sponsored meetings. Secondly, the General Medical Council should insist that all doctors publish payment and hospitality received as a requirement of registration. Free medical education is too sweet to be wholesome.

Des Spence is a general practitioner, Glasgow
destwo@yahoo.co.uk

References are in the version on bmj.com.

Cite this as: *BMJ* 2013;346:f3936

PAST CARING **Wendy Moore**

Ether frolics

As with buses, you wait several centuries for a painless approach to surgery and then four would-be pioneers come along at once. Yet medical immortality is invariably conferred on he (it's usually he) who shouts first and most loudly.

The US dentist William Morton is widely hailed as the inventor of pain free surgery after using ether to extract a patient's tooth on 30 September 1846. A few weeks later, on 16 October, Morton administered ether during an operation to remove a neck tumour from a patient at Massachusetts General Hospital. News travelled quickly. In England, Robert Liston lost no time in claiming the laurels for performing the first operation under ether in Europe after amputating a patient's leg at University College Hospital, London, on 21 December.

But neither were the true pioneers. Morton and Liston were pipped to the post by humbler compatriots. Crawford Long (1815-78), a country doctor in Georgia, first noticed ether's anaesthetic effects after inhaling it himself "for its exhilarating properties" at ether parties in the early 1840s. He observed, "My friends, while etherized, received falls and blows" but "did not feel the least pain."

Eager to apply this miracle to medical practice, Long gave ether to a patient, James Venable, before removing a tumour from his neck on 30 March 1842, four years before Morton's ether day. During the operation Venable gave "no evidence of suffering" and later insisted that he "did not experience the slightest degree of pain."

Long used ether in several more operations to remove tumours and amputate fingers and toes but kept his earth shattering news to himself so that he could test the qualities of the gas more fully. Even after reading of Morton's claim to fame—and attempts to patent ether—in December 1846, Long maintained his silence and only finally published his discovery in 1849.

COLIN CRISFORD

A country doctor in Georgia first noticed ether's anaesthetic effects after inhaling it himself "for its exhilarating properties" at ether parties in the early 1840s

Meanwhile news of Morton's operation had arrived in Liverpool on the ship *Acadia* on 16 December 1846. Five days later Liston used ether to amputate a leg and was confident he had earned a European record. But the ship's surgeon, William Fraser, was faster. He raced to his native Dumfries and relayed the news to a surgeon friend, William Scott. Scott used ether in a leg amputation at Dumfries and Galloway Royal Infirmary on 19 December, beating Liston by two days, but only published his breakthrough 26 years later.

Scott and Crawford may have lamented their obscurity, but millions of patients since have gratefully welcomed oblivion.

Wendy Moore is a freelance writer and author, London wendymoore@ntlworld.com

Sources: See the version on bmj.com.

Cite this as: *BMJ* 2013;346:f3861