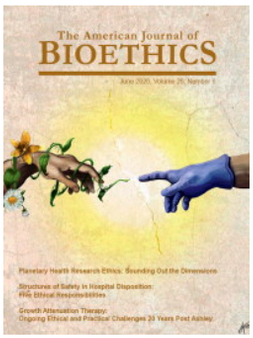

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TARGET ARTICLE

An Ethical Critique of the Doctor's White Coat and the Patient's Gown

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ABSTRACT

This article presents an ethical critique of clinical attire- specifically the doctor's white coat and the patient's hospital gown- through the lens of *enclothed cognition*, which posits that clothing influences cognitive processes and social interactions. The white coat symbolizes medical authority and professionalism but may unintentionally reinforce hierarchical dynamics, overconfidence, and emotional detachment. Conversely, the patient gown may often evoke vulnerability, depersonalization, and diminished respect for autonomy, disproportionately affecting marginalized groups and exacerbating health inequities. Drawing on empirical case studies, ethical theory, and institutional policies, the analysis reveals how clothing in healthcare is a moral artifact shaping power, dignity, respect for autonomy, and justice. The article calls for context-sensitive, inclusive reforms in clinical attire policies, emphasizing the integration of symbolic awareness and patient-centered design. Reimagining medical garments as tools of ethical care—not mere uniforms or convenience- can foster more equitable, respectful, and relational healthcare environments.

KEYWORDS

Doctor's attire; ethical critique' enclothed cognition; healthcare equity; patient dignity; power dynamics

INTRODUCTION

In the sterile, fluorescent-lit corridors of modern hospitals, appearances are not trivial. The patient, clad in a backless hospital gown, often waits on an examination table with a sense of exposure—not just of the body, but of the self. The physician, by contrast, enters the room encased in the symbolic armor of the white coat, a garment that invokes authority, expertise, and professional distance. These clothing items, often considered practical or conventional, are not ethically neutral. Rather, they function as powerful nonverbal scripts that shape cognition, behavior, and social relationships within medical encounters. This observation is substantiated by the theory of *enclothed cognition*, which posits that clothing not only reflects identity but actively contributes to it by influencing psychological processes and interpersonal dynamics (Adam and Galinsky 2012). Since the physician-patient relationship is a personalistic one (Fletcher 1977), it is imperative to critically evaluate the potential role of dress in shaping this relationship.

Healthcare providers' attire, traditionally regarded as a symbol of professionalism and trust in medicine, have been identified as a significant vector for horizontal transmission of pathogens within healthcare settings. Numerous studies demonstrate that white coats frequently become contaminated with pathogenic organisms such as *Staphylococcus aureus*, including MRSA, and *Clostridioides difficile*, posing risks for nosocomial infections. These garments are rarely laundered on a daily basis, allowing microbial colonies to persist and spread between patients, staff, and the community. This reality raises ethical concerns regarding the physician's duty to minimize harm and maintain patient safety, challenging the continued use of white coats in clinical practice (Loveday et al. 2007; Treakle et al. 2009; Wiener-Well et al. 2011; Bearman et al. 2014). However, the implications of clothing in healthcare have largely escaped ethical scrutiny. While discussions of attire have focused on hygiene, professionalism, or aesthetic norms (Rehman et al. 2005), the ethical dimensions of what patients and physicians wear remain underexplored. What does it mean, ethically, that patients are placed in garments that induce vulnerability, dependence, and anonymity? Conversely, what are the consequences of dressing physicians in clothing that amplifies confidence, power, and social distance? These questions become especially urgent in light of empirical findings showing that attire can alter not only how others perceive us, but how we perceive

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ourselves and behave. This psychosocial impact is not benign—it has real consequences for patient autonomy, dignity, and equity in care.

The ethical critique advanced in this article emerges at the intersection of social psychology, bioethics, and medical sociology. It argues that standard medical dress codes—particularly the juxtaposition of the patient gown and the doctor's coat- reproduce and intensify hierarchical power relations in ways that are ethically problematic. Drawing on the theory of enclothed cognition and related scholarship on symbolic embodiment (Goffman 1959; Crossley 1996), the article examines how clinical attire may shape moral agency, can reinforce paternalism, and may even compromise the principles of informed consent and respect for personhood.

This critique is not merely theoretical. Evidence suggests that patient gowns can lead to a diminished sense of identity and self-efficacy, potentially undermining participation in decision-making (Gabay and Ornoy 2024). Likewise, the physician's coat has been shown to elevate perceptions of competence and trustworthiness, even when not warranted by clinical performance. These psychosocial cues matter, particularly in vulnerable clinical moments where asymmetries in knowledge, status, and bodily autonomy converge.

This article therefore calls for a reevaluation of clinical attire as a subject of bioethical inquiry. Through a multidisciplinary analysis, it will argue that what clinicians and patients wear is not simply a matter of institutional habit or hygienic necessity, but a morally loaded practice that warrants ethical reflection, empirical study, and potentially, reform.

THEORETICAL FRAMEWORK: ENCLOTHED COGNITION AND THE SYMBOLIC POWER OF CLINICAL ATTIRE

The concept of *enclothed cognition* refers to the systematic influence that clothing has on psychological processes, including attention, self-perception, behavior, and interpersonal judgments. This theory was first introduced by Adam and Galinsky (2012) in a seminal study demonstrating that individuals wearing a lab coat described as a "doctor's coat" performed significantly better on tasks requiring sustained attention than those wearing the same garment labeled as a "painter's coat." The effect occurred only when the garment was worn and when its symbolic meaning was activated, highlighting two necessary components: the *physical experience of wearing the item*, and the *psychological meaning attributed to it*. These findings challenged earlier conceptions that clothing's influence is solely social or cultural. Instead, Adam and Galinsky proposed that clothing has *cognitive embodiment* properties—it can literally prime certain mental states and alter performance by shaping how the wearer sees themselves. This theoretical insight has since been supported and expanded in numerous studies. For instance, Kellerman and Laird (1982) found that formal attire enhances abstract thinking, while other research has shown that wearing military uniforms can increase compliance and aggression.

In the context of healthcare, clothing plays a particularly potent symbolic role. Medical attire is not just functional- it can demarcate roles, status, and power. The white coat, for instance, is steeped in a history of symbolism. Originating in the 19th century to signal a transition from pre-modern medicine to scientific professionalism, the coat was intended to convey cleanliness, rationality, and detachment (Haiken 2003). Today, it is widely interpreted by patients as a sign of authority, competence, and trustworthiness (Rehman et al. 2005). Its cognitive effects, however, are not limited to the observer. Physicians themselves may unconsciously conform to the behavioral expectations associated with the coat—such as exhibiting increased confidence, assertiveness, or clinical detachment.

By contrast, the patient gown carries radically different symbolic associations. It is designed to provide clinical access and reduce contamination risks, yet it also conveys submission, vulnerability, and institutional anonymity (Gabay and Ornoy 2024). Patients often report feelings of embarrassment, depersonalization, and powerlessness while wearing hospital gowns (Baillie 2009). From the perspective of enclothed cognition, these emotional reactions are not merely side effects of the healthcare environment- they are *partly induced and reinforced by the clothing itself*. Gowns can shape how patients view themselves, interpret their agency, and engage in medical decision-making.

The symbolic meanings of the white coat and the hospital gown resonate with broader sociological theories. Erving Goffman's (1959) dramaturgical theory of social interaction proposed that clothing is a key element in the "presentation of self," helping to define the roles people play in various contexts. In a clinical setting, the stark visual contrast between doctor and patient is a theatrical display of institutional hierarchy. Goffman (1961) also discussed how "total institutions" (like hospitals) often strip individuals of their identity through standardized clothing, further reinforcing conformity and compliance. Crossley (1996), in *Discipline and Punish*, added that institutional attire is a mechanism of control that naturalizes inequality and trains bodies to accept subjugation.

Moreover, clothing acts as a *non-verbal script*, shaping how others treat us and how we behave. This aligns with Bourdieu's (1984) concept of *habitus*- a system of embodied dispositions acquired through social conditioning. In healthcare, both patients and professionals are socialized into specific behaviors and emotional norms, partly mediated through dress. As Twigg (2010) argues, clothing in health and institutional care is never neutral; it is a powerful communicator of class, gender, illness, and legitimacy. Taken together, the white coat and patient gown can do more than differentiate professional roles; they may actively construct divergent cognitive and emotional worlds. While the coat is likely to foster a mindset of control and expertise, the gown can induce a state of dependence, passivity, and diminished self-worth. These psychological states, shaped by clothing, influence communication, trust, and the patient's participation in their own care (Wear 1998). The ethics of these effects must be examined with care.

Furthermore, enclothed cognition offers a bridge between *embodied ethics* and cognitive science. It supports a phenomenological understanding of the body- not merely as an object to be treated, but as a site of meaning, perception, and moral experience (Merleau-Ponty 1962; Carel 2016). When attire disrupts a person's embodied sense of self or reinforces their marginalization, it constitutes not just a psychosocial harm, but an ethical one.

Finally, clothing in clinical settings is also shaped by *institutional practices and cultural assumptions*, often without consideration for individual preferences, cultural norms, or psychological well-being. When patients are routinely denied the right to wear their own garments or express their identity through dress, it raises questions of *epistemic injustice* (Fricker 2007), *respect for autonomy*, and *respect for personhood*.

In sum, the theory of enclothed cognition provides a robust conceptual foundation for analyzing the ethical implications of clinical attire. It highlights how something as seemingly mundane as a coat or a gown can carry profound psychological and ethical weight- structuring the power dynamics, self-perceptions, and interpersonal relations that define the clinical encounter. As the following sections will demonstrate, these insights have serious implications for how we design, regulate, and ethically assess clothing in healthcare environments.

THE PATIENT'S GOWN: PSYCHOLOGICAL AND ETHICAL IMPACTS

The hospital gown, a ubiquitous symbol of modern medicine, is rarely questioned in ethical discourse despite its centrality in shaping the patient's embodied experience. Typically open at the back, loosely tied, and made of flimsy, one-size-fits-all fabric, the gown is designed for practical clinical access-facilitating examinations, procedures, and hygiene control. Yet this apparent neutrality masks a deeper ethical problem: the patient gown contributes to the psychological deconstruction of the self. Through the lens of enclothed cognition, the gown functions not only as a garment but as a *psychological primer* for vulnerability, dependency, and depersonalization.

Loss of Dignity and Embodied Vulnerability

Patients frequently describe the experience of wearing a hospital gown as degrading or infantilizing. In a qualitative study by Baillie (2009), patients reported that gowns made them feel exposed and "not like a person anymore." These garments often fail to adequately cover the body, creating conditions for embarrassment and shame- especially among women, older adults, and those with body image sensitivities (Carel 2016). For religious or cultural minorities, the loss of modesty imposed by standardized medical attire can be particularly distressing.

From a bioethical standpoint, such experiences represent a *violation of dignity*, which the *World Health Organization* and major medical ethics frameworks identify as a fundamental right in clinical care (WHO 2000; Beauchamp and Childress 2013). If clothing shapes not only how others perceive the patient but how the patient perceives herself, then garments that strip away personal identity and bodily integrity directly impinge on the patient's moral status as an agent worthy of respect.

Psychological Priming of Passivity

Enclothed cognition theory helps explain the psychological impact of the gown. The symbolism embedded in hospital attire communicates vulnerability, illness, and submission. Patients internalize these associations, which can unconsciously shift their mindset into a passive, compliant, and less self-assured role (Adam and Galinsky 2012). This is especially concerning in moments where active participation is ethically and clinically critical- such as during the process of informed consent, end-of-life discussions, or the negotiation of treatment plans.

Empirical research supports this concern. Johnson et al. (2010) found that patients wearing gowns were significantly less likely to ask questions, challenge

decisions, or express concerns compared to those wearing their personal clothing. Similarly, Gabay and Ornoy (2024) documented that patients dressed in their own clothes reported higher self-efficacy and sense of agency, even when controlling for severity of illness. These findings suggest that attire is not a superficial or neutral element of care, but a *situational determinant of patient behavior*.

Deindividuation and Institutional Control

Goffman's (1961) analysis of "total institutions" is especially relevant to the ethics of hospital gowns. He argued that institutions like hospitals, prisons, and asylums strip individuals of personal identifiers- clothing, names, possessions- in order to impose conformity and manage bodies. The gown thus functions as a tool of *institutional control*, erasing social markers such as gender, profession, style, and religious identity. This depersonalization may facilitate efficient care delivery, but it also flattens the richness of patient identity into the impersonal "bed number" or "case file." The result is *epistemic injustice*, wherein patients are not only physically vulnerable but also symbolically silenced or diminished as knowers of their own experience (Fricker 2007). When patients feel that their embodied self has been negated or reduced to a mere object of medical attention, it undermines their ability to speak, be heard, and be respected as moral agents.

Intersectionality and Unequal Burdens

The ethical burden of hospital attire is not distributed equally. Research shows that marginalized populations- especially Black patients, transgender individuals, people with disabilities, and the elderly- are disproportionately affected by the negative symbolism and material design of patient gowns. For example, trans and non-binary patients may find the forced binary of male/female gown assignments alienating or distressing, while patients with mobility impairments may experience discomfort or embarrassment when gowns are poorly fitted or difficult to manage without assistance. These patterns raise issues of *justice and equity*. The principle of justice in bioethics calls for the fair distribution of benefits and burdens, yet the gown imposes a unique set of burdens on those already at risk of medical marginalization. When attire amplifies rather than mitigates existing vulnerabilities, it fails to meet even minimal standards of equitable care.

Alternative Models and Design Innovations

Recognizing the limitations of the standard gown, some health systems have begun to experiment with alternative designs. For instance, Boston-based designer Michael Forbes developed the "Janus gown," which closes fully in the back and allows for greater patient coverage without sacrificing access for clinicians. Pilot programs implementing redesigned gowns have reported improvements in patient satisfaction and a decrease in reported embarrassment. Yet despite promising innovations, widespread adoption remains limited. Institutional resistance often stems from cost concerns, logistical inertia, and a lack of awareness about the psychological and ethical importance of clothing. However, if we accept the basic premise of enclothed cognition—that garments shape identity and cognition- then we must also accept that improving patient attire is not a luxury or aesthetic upgrade, but a *moral imperative*.

THE DOCTOR'S WHITE COAT: SYMBOLISM, POWER, AND ETHICAL TENSIONS

If the patient's gown communicates exposure and dependency, the white coat worn by physicians performs the opposite function: it can evoke authority, expertise, and moral legitimacy. Long associated with the image of the competent, benevolent doctor, the white coat has become a nearly sacred symbol of medical professionalism. Yet from an ethical standpoint, the coat's symbolic power is far from benign. The phenomenon of *enclothed cognition* suggests that the coat not only affects how physicians are perceived by others—it also shapes how they perceive themselves and behave. This dual influence raises critical questions about medical power, paternalism, and the subtle ways in which clothing may distort clinical judgment, undermine relational ethics, and reinforce institutional hierarchies.

The Historical Construction of the White Coat

The modern white coat traces its roots to the late 19th century, when medicine was undergoing a transformation from mystical and anecdotal practice to evidence-based science. As part of this professionalization process, physicians adopted the white lab coat- a garment borrowed from laboratory scientists- to signify their new status as empirical, rational healers (Haiken 2003). The whiteness of the coat symbolized purity, sterility, and ethical conduct, distinguishing the modern doctor from quackery and superstition.

Over time, the coat evolved from a mere indicator of cleanliness to a potent symbol of *medical identity*. Today, it is widely regarded as a badge of honor, authority, and trust. Ceremonies such as the "White Coat Ceremony" for medical students reinforce this symbolism, serving as rituals of professional initiation and moral commitment (Wear 1998). However, this institutional glorification of the coat also contributes to its psychological potency—both for the wearer and for the patient.

Cognitive and Behavioral Effects on Physicians

According to enclothed cognition theory, wearing clothing imbued with symbolic meaning can activate behaviors congruent with that meaning (Adam and Galinsky 2012). In the case of the white coat, studies have shown that wearing it can enhance attention, increase confidence, and even improve task performance in clinical simulations. These effects, while potentially beneficial for diagnostic precision or professional composure, also come with ethical complications.

The coat can foster *overconfidence*, especially among junior doctors, leading to a false sense of competence that may impair collaborative decision-making or humility in the face of uncertainty. Additionally, the uniform may unconsciously encourage *emotional detachment*, reinforcing a professional demeanor that favors objectivity over empathy (Gabay et al. 2024). While detachment may be useful in high-stakes scenarios, it can undermine the humanistic dimensions of care that are essential to patient trust and satisfaction.

Furthermore, the coat can serve as a *psychological barrier*, discouraging physicians from acknowledging their own fallibility. The pressure to "live up" to the coat's symbolic expectations may lead to defensive behaviors, reluctance to seek second opinions, or delayed admissions of error- practices that carry ethical risks in terms of patient safety and professional accountability (Berlinger 2005).

Perceptual Bias and Patient Trust

For patients, the white coat is an immediate visual cue that evokes authority, safety, and professionalism. Numerous studies have confirmed that patients perceive physicians wearing white coats as more competent, intelligent, and trustworthy than those in casual attire (Rehman et al. 2005). However, this "white coat halo" can introduce significant perceptual bias. Patients may defer more readily to physicians in white coats, even when they harbor doubts or discomfort about medical recommendations. This dynamic can subtly erode the proper process of *informed consent*, turning what should be a collaborative decision-making process into a passive act of compliance.

Moreover, the coat may perpetuate *hierarchical asymmetries* that inhibit open communication. In interviews with patients from diverse backgrounds, Wear (1998) found that many perceived the coat not as a neutral garment, but as a symbol of *institutional power*- a barrier to being heard, especially for those from marginalized communities. When coupled with the patient's own disempowering attire, the contrast becomes ethically problematic: one person is fully dressed in power, the other stripped down into silence.

The white coat may also produce *affective dissonance* for some patients. For instance, in mental health or trauma care settings, formal medical attire can evoke intimidation or past negative experiences, interfering with therapeutic alliance. In such contexts, the insistence on traditional uniforms may violate the principle of *beneficence* by placing institutional norms above relational care.

Institutional Identity and the Politics of Uniforms

The white coat does not exist in a vacuum. It is part of a broader *aesthetic regime* that governs how professionals are expected to present themselves in clinical spaces. Hospitals and medical schools often enforce explicit dress codes, reinforcing the coat's role as a tool of social control and branding. This standardization may foster internal cohesion among healthcare teams, but it can also inhibit critical self-reflection about the symbolic and cognitive consequences of uniformity.

There is also a *political dimension* to the coat's symbolic power. In many cultures, the coat is a visual shorthand for moral superiority and epistemic authority. It often carries more social weight than a patient's narrative, especially when those narratives challenge dominant biomedical paradigms. This imbalance contributes to *epistemic injustice*, in which patients' voices are discounted or misinterpreted because they lack the visual and institutional markers of credibility (Fricker 2007).

Finally, the coat's symbolic rigidity can alienate physicians themselves. Some clinicians-particularly women, LGBTQ+ practitioners, and physicians of color- report that the uniform imposes behavioral expectations that feel unnatural or constraining. In these cases, the coat becomes a site of *identity dissonance*, prompting ethical questions not only about the treatment of patients, but also about the emotional labor required to maintain a professional image.

Rethinking the Role of the Coat

While abolishing the white coat altogether may be neither realistic nor desirable, its ethical implications must be interrogated. Rather than accepting the coat as a symbol of moral neutrality, healthcare institutions should promote *critical awareness* of its psychological effects. Training programs in medical ethics, communication, and patient-centered care could integrate discussions of *symbolic authority* and enclothed cognition, enabling physicians to wear the coat with intention rather than assumption.

Some settings have already begun to adapt. Pediatricians, mental health providers, and palliative care teams increasingly opt for *soft attire*- scrubs, sweaters, or even personalized coats with less formal styling- to reduce intimidation and foster relational rapport. These shifts reflect a growing recognition that clothing is not only a signifier of clinical identity, but a *modulator of care quality*.

ETHICAL ANALYSIS: POWER, RESPECT FOR AUTONOMY, DIGNITY, AND JUSTICE

The asymmetry between the patient's gown and the physician's white coat is not merely a matter of clothing esthetics or institutional tradition- it is an ethically significant arrangement that reinforces and sustains existing power structures in healthcare. Drawing on the psychological mechanisms of *enclothed cognition* and normative principles from biomedical ethics, this section analyzes how clinical attire interacts with the moral values of *respect for autonomy, beneficence, non-maleficence, justice*, and *respect for personhood*. At the center of this analysis lies a critical question: *How do garments influence the moral architecture of the clinical encounter?*

Power and Paternalism: Symbolic Authority as Moral Risk

The white coat is widely perceived as a symbol of medical expertise and authority, but this symbolism can blur the ethical boundaries between *guidance* and *paternalism*. As discussed in previous sections, the coat enhances perceived trustworthiness and competence (Rehman et al. 2005), but also shapes the physician's self-perception—often increasing confidence and assertiveness. While self-assurance is not inherently unethical, the symbolic priming associated with the coat can unintentionally encourage *hierarchical thinking*, reducing sensitivity to patient input or alternative epistemologies.

This symbolic power can transform the clinical encounter from one of *shared decision-making* to one of implicit compliance, especially when paired with the psychological effects of the patient gown. The patient, disempowered by attire that primes passivity (Adam and Galinsky 2012), may interpret the physician's coat not only as a mark of expertise but as a *justification for silence*. This constitutes a form of *soft paternalism*, in which deference is not demanded but subtly induced. Ethically, this raises concerns about the *abuse of symbolic power*. When clinical clothing interferes with the patient's ability to voice concerns, express preferences, or question authority, it violates the principle of *respect for autonomy*, one of the foundational values in biomedical ethics (Beauchamp and Childress 2013). Autonomy is not simply the ability to make decisions, but the right to make those decisions in a context that does not distort cognition or compromise agency.

Dignity and Embodiment: The Right to Appear Human

The concept of *dignity* in medical ethics emphasizes the intrinsic worth of every individual and their right to be treated with respect, irrespective of illness, status, or capacity (WHO 2000). The hospital gown- designed for functional access rather than patient comfort or expression- often violates this principle by creating feelings of exposure, shame, and objectification (Baillie 2009; Gabay and Ornoy 2024). The garment de-individualizes the patient, signaling their status as a body-to-be-managed rather than a person-to-be-heard.

From a phenomenological perspective, clothing is not just a social artifact but part of the *embodied self* (Merleau-Ponty 1962; Carel 2016). When patients are denied the ability to express identity through dress, or forced into garments that erase individuality, they experience what Havi Carel calls *existential suffering*- the sense that one's self is no longer coherent or visible. In this context, dignity is not abstract; it is deeply *material and sensory*, tied to how the body is clothed, handled, and seen.

Dressing patients in standard gowns with no regard for modesty, culture, gender identity, or comfort constitutes a form of *symbolic violence*- a subtle but pervasive erosion of personhood under the guise of institutional efficiency (Bourdieu 1991; Fricker 2007). Such practices violate the principle of *non-maleficence* by inflicting psychological harm that is neither necessary nor justified by clinical need.

Justice: Inequity in the Fabric of Care

The ethical principle of *justice* demands fair and equitable treatment for all patients, including equitable distribution of both benefits and burdens in medical practice. Yet clothing policies and practices in hospitals disproportionately harm certain groups. Research shows that older patients, women, racial minorities, disabled individuals, and transgender persons are more likely to report distress, embarrassment, or alienation when required to wear standardized hospital gowns. For instance, transgender and non-binary patients may be assigned gowns or room accommodations that misalign with their gender identity, compounding an already stressful medical encounter with experiences of *gender dysphoria* or symbolic erasure. Similarly, Muslim women or Orthodox Jewish patients may face modesty violations when hospital gowns fail to accommodate religious dress codes. These practices do not merely reflect cultural insensitivity—they reproduce *systemic inequities* under the cover of clinical neutrality.

The coat/gown binary thus becomes a visible and embodied form of *structural inequality*, reinforcing whose knowledge counts, whose body is exposed, and whose personhood is affirmed. Ethical practice demands not only recognition of these disparities but active remediation. *Clothing reform-* such as offering culturally sensitive gowns, personalized options, or alternative modes of attire—can be a tangible way to enact justice within the clinical environment.

Relational Ethics and Epistemic Justice

Beyond the individual principles of respect for autonomy and dignity lies the broader ethical domain of *relational ethics-* the view that moral meaning arises through relationships marked by trust, mutual respect, and emotional resonance (Bergum and Dossetor 2005). In this framework, clothing is not merely a symbol but a *relational artifact* that mediates the interaction between patient and provider. When that artifact imposes distance, silences vulnerability, or reinforces hierarchy, it undermines the moral quality of the relationship.

Moreover, clothing can function as a *gatekeeper of credibility*. Epistemic injustice occurs when individuals are discredited as knowers due to structural prejudice or symbolic positioning (Fricker 2007). Patients in gowns- stripped of personal identifiers and institutional legitimacy- are often perceived as passive recipients rather than legitimate contributors to clinical dialogue. This is especially troubling in chronic illness care, mental health, and end-of-life decisions, where the patient's subjective experience should be central to ethical deliberation. In contrast, when attire affirms the patient's identity and humanity, it can enhance the *moral space of care*. Clothing then becomes not a site of domination, but a medium of connection—an embodied way of saying, *You matter. You are seen. You are heard.*

Bias and Inequity in Professionalism Standards

In addition to their impact on patients, attire norms also reproduce inequities within the medical profession itself. Standards of "professionalism" have historically been framed through dominant cultural paradigms- typically white, Western, male, and heteronormative- and have consequently functioned as tools of gatekeeping (Chawla and Alexander 2025). Physicians and trainees whose appearance, hairstyles, clothing, or religious expressions fall outside these norms are often judged as less professional, irrespective of their clinical competence. Recent scholarship has shown, for instance, that women trainees receive more frequent and more negative feedback on attire compared to men, reflecting gendered double standards (Billick et al. 2022). Similarly, racially minoritized physicians may experience disproportionate scrutiny over hairstyles, accents, or cultural dress, reinforcing structural inequities under the guise of neutrality. These dynamics underscore that "professional dress" is not ethically neutral, but rather a socially constructed standard that can perpetuate exclusion and injustice (Ruzycki et al. 2022). Situating attire within this broader critique of professionalism highlights the need for reforms that are not only patient-centered but also equity-oriented for healthcare workers themselves.

PROFESSIONAL AND INSTITUTIONAL PERSPECTIVES ON ATTIRE

Although clinical clothing may seem like a personal or symbolic matter, it is heavily governed by institutional norms, professional identity formation, and historical traditions. The hospital gown and the physician's white coat are not merely individual choices but *systemic artifacts-* regulated by policies, reinforced by rituals, and embedded in medical training. Yet institutional approaches to attire often prioritize hygiene, efficiency, and symbolic professionalism over ethical concerns like dignity, respect for autonomy, or inclusion. This section explores how medical organizations and institutions justify current practices, how these practices are contested, and what reforms are emerging.

Professional Dress Codes and Medical Tradition

Medical institutions have long imposed formal dress codes for staff, often rooted in the ideals of professionalism, discipline, and cleanliness. White coats, ties, and polished shoes have served as visual markers of reliability and competence. In the words of the *American Medical Association (AMA)*:

"Professional attire is a nonverbal communication of responsibility and respect for the profession, the patient, and the public."

(*AMA Code of Medical Ethics*, 2016, Opinion 9.5.1).

Similar views are echoed in the *General Medical Council (UK)*, which states that doctors must "maintain the trust of patients by upholding the appearance of professionalism" (GMC 2013). These standards are often reinforced through medical school rituals such as the *White Coat Ceremony*, first initiated in 1993 at Columbia University College of Physicians and Surgeons and now adopted globally. The ceremony symbolizes the transition from student to healer, embedding the coat not only with clinical authority but with *moral significance*.

Yet these professional norms have been criticized for *fetishizing tradition* at the expense of patient experience and ethical nuance. Critics argue that institutional dress codes often rely on outdated assumptions about authority, cleanliness, and respectability, ignoring the empirical and ethical complexities revealed by contemporary research (Rehman et al. 2005; Twigg 2010).

THE SHORT WHITE COAT AND HIERARCHICAL SIGNALING

The symbolic weight of the white coat begins even before full licensure, with the short coat traditionally assigned to medical students. Unlike the full-length coat worn by attending physicians, the short coat functions as a visible marker of provisional status- granting partial professional legitimacy while simultaneously encoding subordination. This attire distinction is reinforced through rituals such as the White Coat Ceremony, which dramatize hierarchical progression within medicine (Wear 1998). Through the lens of enclothed cognition, the short coat does not merely reflect hierarchy; it primes behaviors consistent with it. Students wearing short coats often report heightened anxiety about appearing competent and reluctance to challenge authority, while the eventual transition to the long coat affirms status and authority (Billick et al. 2022). Ethically, these symbolic gradations may perpetuate intra-professional power asymmetries that influence communication, decision-making, and moral agency within clinical teams.

Institutional Gowning Policies: Safety vs. Humanity

Patient gowns, meanwhile, are usually standardized according to institutional needs for *clinical access, infection control, and laundry efficiency*. Hospitals purchase gowns in bulk, often selecting the most cost-effective designs that allow providers quick access to the patient's body while minimizing contamination risks. Yet rarely do institutional policies include *explicit consideration of patient dignity*, cultural preferences, or identity expression.

Surveys reveal that a majority of hospitals in North America offer *no choice* to patients regarding attire- even in outpatient or noninvasive contexts. While infection control remains a legitimate concern, experts note that many gowning practices are rooted in *habit* rather than evidence. Studies by Lucas and Dellasega (2020) have shown that in many cases, allowing patients to wear their own clothing or alternate gowns does not increase infection risk and can improve patient satisfaction and engagement. This suggests a troubling *discrepancy between institutional inertia and ethical innovation*. When clothing policy is designed solely from a logistical perspective- without regard for the embodied and psychological impact on patients- it risks violating core ethical commitments, including *non-maleficence*, *respect for personhood*, and *justice*.

Resistance to Change: Branding, Hierarchy, and Identity

Institutional resistance to attire reform is not merely logistical; it is also *cultural and symbolic*. The white coat functions as part of the hospital's *brand identity*- a visible shorthand for trust, competence, and authority. In public-facing images, white-coated doctors convey reassurance to donors, policymakers, and the general public. In many teaching hospitals, photographs of doctors without coats are considered unprofessional for promotional materials. This branding logic can conflict with *ethical and relational considerations*. For example, while pediatricians and mental health professionals increasingly recognize the value of soft, approachable attire in building rapport, hospital leadership may discourage departures from formal dress due to perceived damage to institutional image. Thus, even when frontline clinicians seek change, *aesthetic conservatism and hierarchical deference* often block innovation.

Moreover, attire functions as a *status differentiator* within clinical teams. White coats are typically reserved for physicians, while nurses, physician assistants, and other allied health professionals are often required to wear scrubs or different colored uniforms. However, some nurses, especially advanced practice nurses, also wear white coats. This visual stratification can reinforce professional silos and even affect interprofessional respect. Reforming attire protocols therefore requires confronting not only habits but *power dynamics* within healthcare systems.

Emerging Models of Ethical Attire Reform

Inspired by Johm Fletcher's Situation Ethics (1966) who supports relativism, it can be argued that in one context, Fletcher's concept of "loving action" might be to wear the coat (e.g., to reassure a patient who associates it with competence); in another, not wearing it might be more "loving" (e.g., reducing barriers in mental health care or eliminating infection risks). "Loving action" means making moral decisions based on *agapē love*- a selfless, unconditional love for others- rather than on rigid rules or legalistic norms. Accordingly, despite institutional inertia, several progressive models are emerging. Hospitals and design innovators are increasingly experimenting with *patient-centered attire*, such as gowns that close in both the front and back, adjustable for different body types, and made of soft, breathable materials. One notable initiative is the *Patient Gown Project* at Hackensack University Medical Center, which introduced redesigned garments that improved dignity without compromising access or hygiene. Patients reported increased comfort, control, and willingness to engage in their care.

Similarly, academic medical centers like Stanford and the Mayo Clinic have launched *pilot programs* in which clinicians rotate attire styles depending on context—wearing white coats in formal diagnostic settings but opting for scrubs or personalized coats in mental health, geriatrics, and palliative care. These experiments reflect a shift toward *situational ethics in attire*, where clothing is calibrated to the needs of the specific clinical interaction, rather than imposed as a blanket rule. Medical education has also begun to respond. A growing number of curricula now include modules on *symbolism and power in healthcare*, encouraging students to reflect critically on the visual and psychological signals embedded in clothing. These interventions seek to cultivate *reflexivity*, inviting future clinicians to make conscious, ethical decisions about how they present themselves—not just for appearances, but for relational and moral impact (Wear 1998).

PATIENT-CENTERED MODELS WITHOUT GOWNS

In some specialties and care settings- such as outpatient clinics, psychiatric services, and palliative care- patients are often permitted to remain in their own clothing rather than being required to wear standardized gowns. This approach stands in stark contrast to the dominant model of inpatient hospital care, where gowning is nearly universal, even for noninvasive visits. Allowing patients to wear personal attire can preserve a sense of identity, autonomy, and dignity without introducing additional clinical risk in many scenarios (Lucas and Dellasega 2020; Morton et al. 2020). Research suggests that patients who remain in their own clothing report higher comfort levels, improved willingness to participate in care decisions, and reduced feelings of depersonalization (Boddington et al. 2020; Kam and Yoo 2021). These practices, which already operate successfully in non-acute contexts, serve as ethical counterexamples to the presumption that gowning is always necessary. Just as pediatrics and mental health offer models for rethinking clinician attire, these patient-centered practices offer guidance for reducing symbolic and embodied vulnerability. Rather than adopting a one-size-fits-all policy, healthcare institutions can draw on these models to create context-sensitive gowning protocols that respect patient agency while maintaining clinical safety.

Policy Recommendations and Future Directions

For meaningful reform, institutions must go beyond symbolic gestures and revise their *formal policies* to reflect ethical principles. This could include: (a) Offering *patient clothing options* that vary by cultural, gender, and comfort preferences; (b) Training staff in *inclusive gowning protocols*, particularly for transgender, disabled, or religious minority patients; (c) Reassessing *dress codes for clinicians* with attention to relational ethics, patient comfort, and context-specific appropriateness; (d) Incorporating *patient voices* in design and policy decisions about attire; and (e) Allocating funds for gown redesigns as a *quality-of-care measure*, not an aesthetic upgrade. These reforms signal a paradigm shift: from *uniformity and symbolic hierarchy* to *ethical embodiment and responsive care*. Clothing, then, becomes not only a symbol of the

institution's values- but a medium through which those values are realized or betrayed.

CONCLUSION AND ETHICAL CALL TO ACTION

Clothing in healthcare is far more than fabric. It is an embodied language- a semiotic system that communicates authority, vulnerability, professionalism, and power. Through the lens of *enclothed cognition*, we see that garments do not merely signal roles; they *shape cognition*, *prime behavior*, and influence the dynamics of care. From the white coat to the depersonalizing hospital gown, attire in clinical settings participates in the moral construction of identity, agency, and relationship. This article has traced the psychological and ethical consequences of clinical attire, revealing a layered narrative: the doctor's coat can promote confidence and credibility but may also foster distance, overconfidence, and hierarchy. The patient gown, designed for convenience, often induces shame, passivity, and symbolic erasure. Together, they materialize the asymmetries of medicine- who speaks and who is silenced, who is clothed and who is exposed, who is the healer and who the object of healing.

Ethical analysis makes clear that these effects are not merely aesthetic or cultural, but morally consequential. Attire intersects with the following principles of biomedical ethics:

- **Respect for Autonomy** is compromised when patients, primed for passivity by their clothing, feel unable to question or participate actively in decisions about their care.
- **Non-maleficence** is breached when depersonalizing attire inflicts emotional discomfort, distress, or identity loss—harms that are often dismissed as inevitable.
- **Justice** is violated when certain patients- particularly those from marginalized communities- bear a disproportionate share of the harms induced by gowning and dress codes.
- **Dignity and respect for personhood** are undermined when clothing policies prioritize institutional branding or logistical ease over personhood.

Yet this critique is not a condemnation of all tradition, nor a naive call for aesthetic relativism. Rather, it is an invitation to rethink how *visual symbols, cognitive psychology, and ethical values* intersect in the fabric of healthcare. If we accept that attire may alters behavior and perception, then clinical clothing should not be incidental to care—it should be *integral to care design*.

ALTERNATIVE ATTIRE MODELS: LESSONS FROM CONTEXT-SENSITIVE SPECIALTIES

Certain clinical domains have long recognized the potential drawbacks of the traditional white coat and have adopted alternative attire models designed to foster comfort, trust, and relational openness. Pediatricians, for example, often avoid wearing white coats due to concerns that formal medical attire can frighten children- a phenomenon sometimes called the "white coat effect." This intuition is not without empirical support: research on pediatric care environments shows that casual or colorful attire is associated with improved rapport, reduced anxiety, and greater willingness among children to engage in examinations (Sujatha et al. 2021; Singh et al. 2023). Similarly, mental health professionals and palliative care teams frequently choose "soft attire" (e.g., scrubs, sweaters, or professional casual wear) to minimize the psychological distance that formal medical uniforms can impose (Cochran and Upchurch 2021; Lilly et al. 2023). These practices reflect an implicit acknowledgment of enclothed cognition- not only in the wearer but in the observer- and its effect on relational dynamics.

The rationale for such adaptations extends beyond theoretical concerns. The phenomenon known as *white coat hypertension*- elevated blood pressure readings in clinical settings, thought to be triggered by the presence of a healthcare professional- underscores the physiological salience of attire and its symbolic associations (Hossain et al. 2025). While debate remains as to whether this phenomenon is caused directly by the coat or by the clinical encounter more broadly, its persistence across populations suggests that visual cues of authority can amplify patient stress responses.

These specialty-driven attire adaptations offer actionable models for broader reform. They demonstrate that abandoning or modifying the white coat does not erode professionalism; rather, it can enhance trust, communication, and patient-centered care in settings where emotional safety is paramount. Importantly, these innovations align with the ethical principles of beneficence and respect for persons, signaling a shift from symbolic hierarchy to relational attunement. By learning from these contexts, other fields- such as primary care, geriatrics, and oncology- could implement situational attire policies that balance professionalism with psychological and ethical considerations.

POTENTIAL LIMITATIONS TO THE ARGUMENTS PRESENTED IN THIS ESSAY

Contextual and Cultural Variability

The symbolism of the white coat and gown is not universal. In some cultures, the white coat may be less

strongly associated with authority, or the hospital gown may not evoke the same sense of vulnerability. My argument may risk overgeneralization if it assumes uniform psychological responses across diverse societies and healthcare systems.

Risk of Reductionism

Attire is only one factor shaping patient-provider dynamics. Communication skills, institutional culture, patient health literacy, and interpersonal trust also profoundly influence autonomy and dignity. Overemphasis on clothing may understate these intersecting determinants.

Patient Heterogeneity

Not all patients experience gowns negatively or perceive white coats as intimidating. Some patients explicitly prefer the coat for reassurance, or feel indifferent about gowning. It is therefore advisable to fully engage with this heterogeneity.

Implementation Barriers

Ethical calls for attire reform may overlook financial and logistical challenges, especially in resource-limited settings where redesigned gowns or flexible attire policies may be cost-prohibitive. Without considering feasibility, proposed reforms could be dismissed as idealistic.

Potential Professional Pushback

Physicians and institutions often see the white coat as integral to identity, ritual, and branding. Although my critique acknowledges this briefly, it may nevertheless underestimate how resistant to change professional culture can be.

A VISION FOR ETHICAL ATTIRE IN HEALTHCARE

An ethically responsive approach to attire would be: (a) *Context-sensitive*: Recognizing that the same garment may foster comfort in one setting and intimidation in another; (b) *Inclusive and customizable*: Offering patients a degree of choice in what they wear, within clinical constraints; (c) *Symbolically aware*: Encouraging clinicians to reflect on how their clothing influences their presence, authority, and relationships; (d) *Grounded in evidence*: Drawing on empirical research on enclothed cognition, patient preferences, and communication outcomes; and (e) *Co-created*: Involving patients, especially from vulnerable groups, in the redesign of gowning and dress policies. Some reforms are simple and low-cost-like offering modesty garments, gender-neutral options, or soft scrubs in psychiatric and palliative settings. Others require structural shifts in policy, budgeting, and education. But all begin with a *change in moral imagination*: the willingness to see clothing as a site of care rather than compliance.

THE ETHICAL OPPORTUNITY

The coat and the gown have long been seen as fixed, neutral, or even sacred elements of clinical practice. This article suggests otherwise. These garments carry with them *symbolic burdens and opportunities*. When misused, they reproduce asymmetries and reinforce institutional detachment. But when reimagined with empathy and equity, they can become tools of connection, affirmation, and ethical care. It is time for clinicians, educators, designers, and administrators to ask a new kind of question- not merely, *"Is this clean and functional?"* but *"What does this garment do to the person who wears it?"* and *"How does it shape the ethical space between us?"* The ethics of clinical attire is not a matter of fashion. It is a matter of justice, of voice, of being seen.

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