Patients or clients?

Sir: As the charm of the word 'client' when used instead of 'patient' has always eluded me, I was delighted to read that the overwhelming majority, namely about 80%, of the patients questioned by Drs Upton, Boer and Neale (*Psychiatric Bulletin*, March 1994, **18**, 142–143) preferred to be called 'patients' rather than 'clients', 'service user', 'customer' or 'consumer'. The social workers, psychologists, nurses and 'carers' of 'clients' and the advocates of 'user' involvement should take note. The word 'patient' is derived from the Latin verb 'pati' (=to suffer) and literally means 'one who suffers' and then, of course, 'someone who suffers from an illness'. The word, at least when used in this sense, does not in itself imply dependence. Those who object to its use because they think that dependence is implied may be interested to know that the word 'patient' has retained this sense only in the curious jargon of modern linguistics, where the subject of a verb is sometimes referred to as the 'actor' and the object of the verb is then called the 'patient'.

Ironically the word 'client', also derived from the Latin ('cliens'=literally 'one who listens', and thus a plebeian dependent on a Roman patrician or patron) is historically much more closely associated with the concept of dependence (compare the expression 'client state') and it was only by about the 17th century that it began to acquire the meaning of 'someone who makes use of professional services', in short a 'customer'. But in the new agoraphilic (='fond of the marketplace') NHS it is not patients who purchase 'healthcare services' but trust commissioners and fund-holding GPs. Hence the conclusions of Upton *et al* should not surprise us: patients still prefer to be called what they are rather than what they are not.

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Sir: The issue of the term 'patient' (*Psychiatric Bulletin*, March 1994, **18**, 142–143) is not new. Shortly after he was appointed Superintendent of the McClean Psychiatric Hospital in Boston, Massachusets in 1879, Dr Edward Cowles wrote, "Once within the hospital the conduct of physicians and nurses towards the patient should show that he is regarded as simply ill, as having no reason for being ashamed of his illness. Therefore he should always be called a 'patient' and not a 'boarder', as is the custom in some hospitals and has been in this one from its earliest days. The latter term implies an evasion of the fact of illness, as if it were a disgrace, and by euphemism fosters the very feeling of which we are trying to disabuse the patients."

The term 'patient' evokes connotations of the rights, expectations and obligations of someone who is ill. The understanding of these benefits and obligations are of great use to both the patient and the people looking after him. The use of words such as 'resident' or 'client' which have very different meanings, implying different relationships, may actually be misleading and detrimental to patient staff relationships. The majority of the patients in the survey were comfortable with being called patients and it would seem sensible to remember the adage 'if it ain't broke don't fix it'.

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Prescribing drugs in emergencies

Sir: Cunnane rightly comments on the lack of consensus among psychiatrists when prescribing drugs for rapid tranquillisation (*Psychiatric Bulletin*, March 1994, **18**, 138–139). In particular, it is alarming that 15% of consultants participating in an emergency on-call rota did not feel competent to give an opinion, and 14% did not expect to bring the situation under control in under 24 hours. This finding may represent, at least for some sub-specialty consultants, a relative distancing from the acute emergency situation and a lack of familiarity with the available preparations.

We feel it is important to widen discussion on this issue to include the opinion and experiences of junior medical staff. In practice, although a consultant may be available to advise on medication, we believe that responsibility for prescribing in an emergency will frequently fall to the most readily available doctor. This may be the ward-based or duty doctor, but in either case he or she is likely to be a senior house officer (SHO) or registrar, making decisions under stressful conditions, often relating to unfamiliar patients and without full information or instance access to advice from senior colleagues. Newly appointed SHOs and GP trainees may have only limited experience in the use of drugs for behavioural control and their potential hazards. Our own study, underway, may shed some light on problems encountered by junior and senior staff.

We were also surprised to find chlorpromazine given as drug of first choice by 50% of respondents, despite some recommendations to avoid the intramuscular route (*Drugs and Therapeutics Bulletin*, **29**, August 1991). In contrast, no mention was made of zuclopenthixol acetate (Clopixol Acuphase) which is widely used in our practice. This preparation has the advantages of a single, variable dose, rapid onset of action and effects lasting up to three days, although more frequent doses may be given if required.