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trust and in the wider NHS. These will include the National Service Framework (Department of Health, 1999) and guidelines from the National Institute for Clinical Excellence that will affect local practice. The committee takes an overview of the process and can advise a steering group if an important area of practice has been overlooked. The local application of initiatives emerging from the presentations is fed into the Development Advisory Committee, a pre-existing structure examining overall site development and clinical activity. How this group will deal with the suggested innovations is awaiting evaluation. Involvement in the clinical governance programme may in the future form a component of the annual performance reviews of doctors and other health professionals. New acquisitions for the academic library may be suggested by the Clinical Governance Programme. This is another means by which clinical governance and the local components of continuous professional development can be woven into a coherent programme.

As yet there is no involvement from professionals in pharmacy and speech therapy owing to their part time presence at the Langdon site. It is hoped that members of these groups will join steering committees in the future. Unfortunately, Langdon receives no additional NHS funding for its clinical governance programme and it has relied on the goodwill of many staff, who invest time over and above their clinical, managerial and secretarial workload. In contrast, local health authorities have been able to appoint new staff specifically for the purpose of clinical governance, despite the fact that it is providers such as Langdon who will have to deliver it.

A functional clinical governance programme is possible and is likely to produce considerable benefits, but it requires substantial multi-disciplinary commitment. It is still too early to evaluate any long term changes in patient care resulting from the programme. To be sustainable in the long term it may need additional funding, especially for an administrator to coordinate the process. The creation of academic posts linked directly to clinical governance has also been suggested (James, 1999).

Conclusion

The Langdon initiative meets the objectives of clinical governance. It ensures a framework for the regular appraisal of new practice in a variety of areas and the dissemination of new information to as wide a staff group as possible. It also gives a forum for the professional development of all clinical personnel, including involvement in regular clinical audit and risk management, as well as a mechanism for incorporating the views of service users. It should allow all groups to play a role in the future direction of patient care at Langdon hospital. Although it is still too early to assess long term benefits to patient care, other mental health services might consider using this model.

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C. W. RITCHIE, D. HAYES AND D. J. AMES

Patient or client? The opinions of people attending a psychiatric clinic†

AIMS AND METHOD

The use of the term 'client' has become increasingly popular among non-medical staff in psychiatric practice. We sought to describe the preferences and attitudes of people attending a psychiatric clinic to the terms patient and client. A questionnaire and case note review was employed.

RESULTS

147 people completed the questionnaire, of these 77% preferred the term patient. There was no subgroup that preferred the term client. Attitudes towards the two terms were significantly different, with a greater antipathy demonstrated towards the term client.

CLINICAL IMPLICATIONS

The majority of people attending a psychiatric clinic prefer the use of the term patient; the term client is disliked.

†See editorial, p. 441, this issue.

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The ongoing debate regarding appropriate nomenclature to describe health care users has been recently highlighted again in the medical literature (Neuberger & Tallis, 1999), principally involving the appropriateness of the terms patient and client.

Those objecting to the term patient do so for a variety of reasons. They argue that both the derivation of patient (*patiens* – to suffer or bear) and modern usage imply an unequal relationship, label people as ill and do not allow the sufferer to demonstrate responsibility in maintaining their own health (Neuberger & Tallis, 1999). However, etymological and semantic criticism applies equally to the word client, derived from Latin (*cliens*) and meaning "one who is obliged to make supplications to a powerful figure for material assistance" (George, 1998). Supporters of the term patient argue that the term client lacks the compassion and trust inherent within the relationships between the sick and their carers (Neuberger & Tallis, 1999). There are few published studies to inform this debate (Upton *et al*, 1994; Nair, 1998) and these do not examine preferences across a comprehensive range of demographic variables. Furthermore, neither study assessed the attitudes of health care users to the terms patient and client.

The use of the term client is particularly prevalent in psychiatric settings, especially among non-medical staff. In the current climate of evidence-based practice there is little critical support for its use. The aim of the present study was to determine the preference for, and attitudes to, the terms patient and client in individuals attending a psychiatric out-patient clinic.

Subjects

The study was conducted in the psychiatric out-patient department of an NHS inner London teaching hospital over a 2-week period after ethical approval was obtained. The clinic predominantly manages general adult psychiatric problems, although those attending the specialist eating disorders and sexual disorders clinics were also included in this study. The old age and child psychiatry clinics are conducted elsewhere and, therefore, elderly people and children are not included in this sample. All those who had appointments over the 2-week period were eligible for inclusion in the study.

Method

Data were gathered from a self-administered questionnaire and the subjects' case-notes. The questionnaire determined subject preferences to three choices of term (patient, client or other), their attitudes (to patient and client using a five-point Likert scale) and socio-demographic and psychiatric data (Table 1). Subjects were also asked to comment on their choice of term. Missing data and diagnostic data for both the sampled and non-sampled individuals were captured from their case notes by the investigators. Social class was derived from occupation using standard criteria (Department of Health, 1996).

The Likert scales, which asked for the individual's attitude to the terms patient and client, were scored from 'strongly dislike' (one) to 'strongly prefer' (five). In an attempt to minimise the 'halo' effect, the clinic reception staff distributed and received back the questionnaires prior to the appointment. The study was identified as being coordinated by the hospital, not by the medical staff.

Results were analysed using the independent sample *t*-test for continuous variables (including mean scores

Table 1. Frequencies of choice of term patient or client by demographic and diagnostic variables

Variable	Patient *n* (%)	Client *n* (%)
Gender		
Male	51 (77)	15 (23)
Female	52 (76)	16 (24)
Age (years)		
Mean	39.54	35.85
In-patient treatment		
Previous admission	53 (70)*	23 (30)*
No previous admission	50 (86)	8 (14)
Mental Health Act status		
Involuntary in-patients	9 (69)	4 (31)
Voluntary patients	44 (70)	19 (30)
Doctor's grade		
Professor	7 (70)	3 (30)
Consultant	24 (82)	5 (18)
Senior registrar	23 (77)	7 (23)
Registrar	17 (77)	5 (23)
Senior house officer	32 (80)	8 (20)
Time patient		
< 1 month	13 (76)	4 (24)
1 month to 1 year	29 (78)	8 (22)
1 year to 5 years	28 (80)	7 (20)
> 5 years	27 (75)	9 (25)
Diagnosis		
Depression	33 (92)	3 (8)
Schizophrenia	16 (76)	5 (24)
Psychosexual	13 (76)	4 (24)
Eating disorder	12 (75)	4 (25)
Bipolar disorder	12 (80)	3 (20)
Other	10 (58)	7 (42)
Ethnicity		
White UK	67 (79)	18 (21)
White Irish	10 (100)	0 (0)
White other	15 (71)	6 (29)
All other	10 (59)	7 (41)
Social class (occupation)		
I	11 (92)	1 (8)
II	17 (74)	6 (26)
III	27 (80)	8 (20)
IV	17 (71)	7 (29)
V	16 (89)	2 (11)
Student	4 (67)	2 (33)
Employed		
Yes	35 (78)	10 (22)
No	65 (76)	20 (24)
Retired	3 (75)	1 (25)

*P=0.02, d.f.=1 (χ^2, Pearson) *v.* no previous admission.

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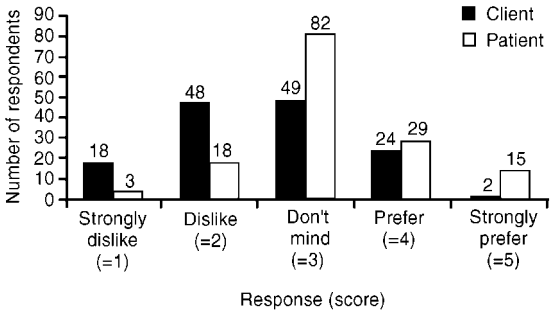

Fig. 1. Number of respondents by attitudes towards terms patient and client

from the Likert scales) and chi-squared for categorical data. In the comparison of preference for terms those who listed 'other' had their data excluded from the analysis.

Results

Attendance

During the study period 314 people had appointments, of which 184 (59%) attended. Of the attendees, 147 (80%) completed the questionnaire, 32 (17%) were erroneously not given questionnaires by the reception staff and five (3%) refused.

Preference of terms

Of those who expressed a preference for either patient or client (96%), the majority preferred the term patient (77% patient, 23% client). This did not vary significantly by socio-demographic grouping or psychiatric diagnosis, other than an increased majority in favour of the term patient was stated by subjects who had never been in-patients (P=0.02) (Table 1).

Attitudes

Forty-seven per cent of the sample either 'disliked' or 'strongly disliked' the term client and 14% felt the same way about the term patient. Moreover, only 1% 'strongly preferred' the term client and 10% the term patient (Fig. 1). The mean score derived from the Likert scale was significantly lower for the term client (2.60) than patient (3.24; $P<0.001$), demonstrating much greater antipathy towards the term client.

Particular groups demonstrated significantly different strength of feeling towards one or other term. Men and people over the age of 40 demonstrated a significantly more positive attitude towards the term patient than younger people and women. Moreover, a diagnosis of depression, White UK ethnicity and never having had an in-patient stay were associated with significantly greater antipathy towards the term client than the remainder of the sample in each of these variables (Table 2). There was, however, no group that showed a positive attitude towards the term client.

Non-sampled *v.* sampled subjects

People previously admitted involuntarily were less likely to attend their appointment ($P<0.001$). However, former involuntary patients who did attend chose terms at similar rates to former voluntary in-patients and demonstrated similar attitudes to the two terms. There were no other significant differences between those sampled and those not sampled.

Discussion

Our study is the first systematically to measure attitudes to the terms patient and client in a psychiatric out-patient setting and compare rates of choice across standard socio-demographic and psychiatric variables. The majority

Table 2. Attitudes to the terms patient and client derived from Likert scales

Attitude to terms	Means	Means	Mean difference (95% CI)	*P* value[1]
	Male	Female		
Patient	3.37	3.06	0.28 (0.002 to 0.56)	**0.049**
Client	2.54	2.65	−0.11 (−0.43 to 0.21)	0.508
	Age <40	Age >40		
Patient	3.10	3.44	0.34 (0.0 to 0.62)	**0.024**
Client	2.69	2.42	0.27 (−0.65 to 0.59)	0.115
	Previous in-patient	Never in-patient		
Patient	3.19	3.30	−0.12 (−0.40 to 0.17)	0.43
Client	2.77	2.36	0.41 (0.09 to 0.73)	**0.012**
	White	Non-white		
Patient	3.32	3.09	0.23 (−0.06 to 0.52)	0.123
Client	2.47	2.82	0.35 (0.03 to 0.68)	**0.034**
	Depression	Non-depression		
Patient	3.25	3.27	−0.02 (−0.35 to 0.31)	0.9
Client	2.21	2.68	0.47 (0.12 to 0.84)	**0.006**
	Patient	Client		
Total sample (mean)	3.24	2.60	0.64 (0.42 to 0.85)	<0.001

1. Independent sample *t*-test (significant differences in bold).

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of subjects chose the term patient irrespective of how they were grouped. Further, the term client was disliked by almost half of those sampled, whereas there was little antipathy towards the term patient. No group had a positive attitude towards the term client.

In everyday usage the term patient is associated with a traditional relationship with a doctor, and client with a business relationship. The semantics of the term have been discussed already. The relationship between health care provider and the individual they care for is extremely complex, although an individual's preference for term of address does provide some insights into our understanding of this relationship.

The observation in our study that people over the age of 40 had a greater liking for the term patient may reflect their wish to retain traditional terminology to describe their relationship with their hospital. Furthermore, the dislike of the term client by those who are depressed may indicate a resistance to a term that lacks compassion and connotations of care. The relative acceptance of the term client by those who have had psychiatric in-patient stays may be a result of their exposure and subsequent adjustment to the term because it is commonly used by non-medical in-patient staff. It is harder to explain why men show stronger liking for the term patient than women do, and why those from a White UK background show stronger dislike for the term client.

Pimlot's introduction to *Nineteen Eighty-Four* in reference to 'Newspeak' suggested,

> "Orwell was making an observation that is as relevant to the behaviour of petty bureaucrats as of dictators, when he noted the eagerness with which truth evaders shy away from well-known words and substitute their own." (Pimlott, 1989)

According to our research, the substitution of the term client for patient has little support from the user's perspective. We feel that those who argue that the term client is empowering should demonstrate consistency with this perspective, respect the opinion of their 'clients' and return to using the term patient. Advocating alternative terminology in a psychiatric setting, despite the above evidence, demands reflection upon the source of one's objection to the clearly expressed, preferred appellation of patients.

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D. TAYLOR, L. SHAPLAND, G. LAVERICK, J. BOND AND J. MUNRO

Clozapine – a survey of patient perceptions

AIMS AND METHOD

We aimed to find out how patients on clozapine felt about clozapine treatment. A structured questionnaire was given to 1284 consecutive patients attending 27 clozapine clinics in the UK.

RESULTS

The response rate was 44.4% (570 forms returned). This cohort of responders to the questionnaire consisted, for the most part, of Caucasian males who had been taking clozapine for more than 2 years. Respondents expressed largely favourable views on clozapine treatment. For example, 86.1% claimed to feel better on clozapine and 88.6% claimed to prefer to remain on clozapine than to change to another drug. Many patients stated that they disliked having to undergo blood testing, but a large majority (87.0%) felt that the advantages of clozapine outweighed disadvantages. All other responses supported this overall favourable view of clozapine therapy.

CLINICAL IMPLICATIONS

Patients stabilised on clozapine are largely content with their treatment. These results suggest that clozapine is effective as assessed by patients' own standards and that adherence to therapy is likely to be good.

DECLARATION OF INTEREST

L.S., L.G. and J.B. are employees of Novartis Pharmaceuticals UK.

Clozapine is an established treatment for schizophrenia that is resistant to therapy with other antipsychotics. It is clearly more effective than conventional drugs in the treatment of schizophrenia (Wahlbeck *et al*, 1999) and has unarguable efficacy in treatment refractory illness (Kane *et al*, 1988). No other drug has been shown unequivocally to have comparable efficacy in this subgroup of patients (Fleischhacker, 1999; Taylor, 1999). Clozapine thus remains the drug of choice in treatment-resistant schizophrenia.

The widespread use of clozapine is very probably inhibited by its acute adverse effect burden (Dev &

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