

for examination and whether winning the prize influenced their later career choice).

Tidying my office for Christmas I came across your letter in November's *Psychiatric Bulletin*. As [the Laughlin Prize] winner in 1981 I fall outside of your survey dates but am intrigued by it. I agree that it is a rather uncelebrated achievement and the personal characteristics of . . . winners may account for some of that. It did have an influence on me I think, although one never knows what the alternative future would have looked like. I have met three other Laughlinites who have passed through my Department and I also went to visit Dr Henry P. Laughlin and his wife when I worked in the [USA] on an RCPsych travelling fellowship. They were a delightful couple. For what it is worth I agree with your extrapolation from a small sample size that enjoying the exam contributes to success although I also think that there is a huge amount of luck involved. My recollection of the Membership Exam (as it then was) was of a good day out and of not being at all intimidated by my two very distinguished London based psychotherapist examiners. I suspect that I could do this because I had been fortunate enough to have been trained in a first class centre where I was used to such grillings and it was relatively easy to take the exam in my stride as no different to my normal daily routine.

- 1 George S. The 'special' ones: survey of Laughlin Prize winners (letter). *Psychiatr Bull* 2009; **33**: 438–9.

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Empowerment and the recovery model

I would not argue against the underlying principles espoused by Sugarman *et al*¹ and Warner.² The principle of working with patients to help them to make informed decisions about options for their healthcare is embodied in the General Medical Council's (GMC) guidance,³ which says that doctors must listen to and work in partnership with patients, and respond to their preferences.

Many psychiatric disorders are exacerbated or precipitated by stress. Autonomy of action is associated with enhanced self-esteem, reduced stress and improved health. Meaningful employment contributes in many ways, giving a sense of purpose and value, enhanced social status, structure and stability, opportunities for social interaction, and improved leisure and social opportunities as a result of greater disposable income.

Those working with individuals who have mental illness should be aware of these principles and seek to incorporate them in the care they offer. In practice, however, professionals nominally subscribing to a 'recovery model' may have a poor

understanding of its complexity. An inappropriate application of the concept of empowering patients can lead to a laissez-faire approach of simply endorsing the patient's choice. This can result in justifying a patient's discontinuation of treatment and withdrawal from engagement with professionals. Such withdrawal can lead to relapse and a deteriorating prognosis, and may itself be indicative of incipient relapse.

Professionals do not enjoy a monopoly of wisdom. We cannot reliably predict the course of a patient's illness or how they might respond to treatment. Those with capacity have the right to decide not to accept treatment or to deal with their illness in ways which professionals may consider unwise. However, GMC guidelines also say that doctors must provide effective treatments based on the best available evidence. The doctor's duty to provide the best advice may include advising a patient that their intended course of action is likely to lead to an adverse outcome. It is incumbent upon us to inform patients of the probable consequences of their decisions and to continue efforts to engage them when we consider them to be at significant risk of deterioration or relapse.

Additionally, UK and European law takes a special view of mental disorder and allows for the patient's autonomy to be overridden. It is a matter of judgement, governed by legislative safeguards, as to when this should occur. Such powers are generally only exercised when the patient's ability to understand is so impaired as to render them incapacitated but a decision to override the decision of a capable patient may be made when the protection of others is in question.

It is right to adopt a positive approach, hopeful of recovery, after a first episode of psychosis. However, rather than adopt unqualified optimism, we should refine our approach using our knowledge of factors favouring a good prognosis. Such features include: acute as opposed to insidious onset; clear and proximate psychogenesis; and the presence of marked affective features in the symptomatology. Several interventions can improve the prognosis and reduce the risk of relapse. Warner² points out the more favourable prognosis in low- and middle-income countries. One explanatory hypothesis is that the recovering patient is more likely to have a valued occupational role. Continued antipsychotic medication reduces the risk of relapse. Psychosocial interventions to assist the patient in better understanding the illness and its behaviour, as well as working to modify family attitudes and environments appear to help. Complete resolution of symptoms encourages optimism about prognosis, but hopes for a meaningful and lasting recovery need to be underpinned by appropriate support and treatment to reduce the risk of relapse.

Despite the advances made in treating the acute symptoms of schizophrenia and preventing acute relapse, social recovery rates do not appear to have improved since Eugen Bleuler coined the term schizophrenia.⁴ Warner quotes a 40% social recovery level but, at the start of the 20th century, Bleuler considered that 60% of his patients showed only 'mild deterioration', that is, had preserved the ability to pursue an occupation.

Whereas, therefore, I accept that significant numbers of patients with schizophrenia can remain symptom-free and that others lead reasonably productive lives, it is still the case that the majority will experience a degree of impairment of function

and many will suffer frank relapses of their positive symptoms or chronic levels of such symptoms.

Psychiatrists should strive to achieve that those diagnosed with schizophrenia are treated so that they become as free as possible of symptoms (including adverse effects of treatment) and that they, their families and carers have as good as possible an understanding of the nature and behaviour of the illness, so that they can make effective informed decisions about their future healthcare. True empowerment requires the individual to have the best information available and the fullest command of their intellectual abilities in order to reach considered decisions based on that information.

The experience of psychosis is traumatic and bewildering. The course of the illness is unpredictable and frequently fluctuating. Those who have experienced it should have ongoing advice, support and treatment to cope with this.

- 1 Sugarman P, Ikkos G, Bailey S. Choice in mental health: participation and recovery. *Psychiatrist* 2010; **34**: 1–3.
- 2 Warner R. Does the scientific evidence support the recovery model? *Psychiatrist* 2010; **34**: 3–5.
- 3 General Medical Council. *Good Medical Practice*. GMC, 2006.
- 4 Bleuler E. *Dementia Praecox or the Group of Schizophrenias*. International University Press, 1950.

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'Patients' – preferred and practical?

Simmons *et al*¹ suggest that the majority of recipients of mental health services do appear on the whole to prefer the term patient, according at least to evidence from studies in London and Hertfordshire.

Although our guidelines prefer other terms, the American Psychiatric Association practice guidelines² exclusively use the collective patients to refer to individuals receiving psychiatric care. Similarly, the Canadian Psychiatric Association clinical practice guidelines (such as those for treatment of depressive disorders³) refer solely to patients. Although other terminology is in use and under debate, patients is possibly also preferred by Canadian recipients.⁴ Cultural differences in attitudes to psychiatry and the organisation of healthcare services may account for the difference in terminology.

I wonder to what extent individuals receiving mental health services who are or have been detained formally under the Mental Health Act in the UK would consider themselves clients or service users. It is possible that those that have been detained (currently or in the past) may prefer the term patient (because they were admitted to a hospital), whereas those individuals who receive or have received treatment primarily in the community may have a different perspective of mental health services and prefer terminology with fewer associations with perceived paternalism.

A final consideration might be to what extent the incorporation of the terms client and service user into psychiatric parlance, if fully embraced, would be practical when taken to its logical conclusions – should we, for example, be

referring to 'in-clients' and 'out-clients' rather than in-patients and out-patients?

- 1 Simmons P, Hawley CJ, Gale TM, Sivakumaran T. Service user, patient, client, user or survivor: describing recipients of mental health services. *Psychiatrist* 2010; **34**: 20–3.
- 2 American Psychiatric Association. *Psychiatric Practice Guidelines*. APA (http://www.psych.org/MainMenu/PsychiatricPractice/PracticeGuidelines_1.aspx).
- 3 Canadian Psychiatric Association. *Clinical Practice Guidelines for the Treatment of Depressive Disorders*. CPA, 2001–2 (https://ww1.cpa-apc.org/Publications/Clinical_Guidelines/depression/clinicalGuidelinesDepression.asp).
- 4 Sharma V, Whitney D, Kazarian SS, Manchanda R. Preferred terms for users of mental health services among service providers and recipients. *Psychiatr Serv* 2000; **51**: 203–9.

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Service user carries a stigma

The term service user is one I employ reluctantly. In my opinion it carries a stigma and leads to denial of the patients' rights to have effective treatment. I think using the term is part of the movement to 'socialise' psychiatry and we need to insist that psychiatric illnesses are similar to any other illnesses, and those who suffer from them are patients. Do cardiologists refer to patients with myocardial infarctions as service users?

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Ancient origins of the term patient

The word patient originally meant 'one who suffers'. The English noun comes from the Latin word *patiens*, the present participle of the verb *patior* meaning 'I am suffering'.

The word patient has been used for hundreds of years but it is only recently that non-medical and non-nursing disciplines have started to advocate the use of words client or service user.

At the heart of this lies the social model of care which intends to demedicalise the management of illnesses so that patients may move away from the medical model, which is perceived to include 'labels' and 'pharmacological treatments'.

By calling people patients I do not believe that we are making them sicker or denying them their rights, as has been popularised; on the contrary, we are helping to continue the unique doctor-patient relationship. This relationship has evolved over centuries and is built on mutual respect, knowledge, trust, shared values and openness.

Patients themselves like to be called patients as evidenced in a few recent studies. Likewise, when I am ill, I would rather be called a patient and not a client, which has some distasteful connotations to it. Also, I would like to be called a doctor rather than a provider, teacher, clinician or advisor, even though my role might vary from patient to patient.

I find it hard to understand how by retaining the word patient one cannot achieve a secure base, supportive