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.

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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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doi: 10.1192/pb.34.3.116

'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 guidelines[2] 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 disorders[3]) 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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doi: 10.1192/pb.34.3.117

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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doi: 10.1192/pb.34.3.117a

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

relationships, hope and empowerment, and aim to be a productive member of the community.

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doi: 10.1192/pb.34.3.117b

Doctor, I presume?

I routinely ask my new patients how they want me to address them and *vice versa*.[1] I have not kept records so my data are approximate.

Nearly all my patients want me to call them by their first name. About a third to a half say they wish to call me by my first name, although not all consistently do so; one expressed a preference to call me 'Doc'.

I routinely ask my new trainees the same questions. So far all have expressed a preference for me to call them by their first name, and about 95% wish to call me by my first name, usually doing so.

Mental health review tribunals usually ask patients how they wish to be addressed, but do not ask staff this nor indicate how they themselves wish to be addressed (I personally take my cue from patients' legal representatives and call them Sir or Ma'am). All patients I can remember have expressed a preference to be called by their first name; all tribunals I have attended address the professionals by title and surname, thus creating disparities.

It is now usual for consultant colleagues to call each other by their first names (when on talking terms!). However, I have a consultant colleague who is younger than me (although now senior in medical management terms) who calls me by title and surname, although I have asked him to address me by forename; he considers that calling me by my forename would be disrespectful. I now rarely hear the surname alone, which used to be commonplace; a few colleagues have accepted abbreviations or other appellations.

I am aware that nursing colleagues mostly find it hard to call me by my first name, even when I have requested this, and some of them have commented on the difficulty they experience. I personally find it offensive to be routinely addressed in impersonal terms by a nurse I have worked closely with for over a year – this is usually Doctor but occasionally a random endearment such as 'sweetheart' that some nurses habitually use with patients and colleagues.

The situation is complicated by the third person. Nurses routinely call me Dr Dodwell to patients, even when I am on first-name terms with both nurse and patient in one-to-one situations, and I notice that patients pick up on this and call me Dr Dodwell in front of the nurse. This occurs even when I have explicitly asked the nurse not to use this form of address. When I am with patients, I often call medical colleagues – consultant and junior – by Dr plus surname, and do so inconsistently with colleagues.

1 Allen JC. Another greetings survey? (letter) *Psychiatrist* 2009; **34**: 36.

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doi: 10.1192/pb.34.3.118