

COMMENTARY

PATIENTS, CLIENTS, CONSUMERS
The politics of words

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While faithfully reading the most recent number of Family Systems and Health , subtitled "Special Issue on "Consumers and Collaborative Care" (18[2], 2000), I was struck by how comfortably as taken center stage in our professional language that rather recently adopted term, "consumer."

As frequently happens when I find myself intrigued by a language conundrum, I launched a frantic exploration of the etymological roots and evolving meanings of "consumer" and associated words, shaking in the process the branches of synonyms and antonyms to see whether any succulent fruit may falls from them. (And to start with, funny words, "conundrum" and "frantic", the former a whimsy word that appeared in the slang of British universities probably parodying some Latin scholastic phrase, and the latter rooted in the Greek frenitis, i.e., "inflammation of the brain"!)

There is a saying in Spanish "A las palabras las carga el diablo" (that is, "Words are loaded by the Devil.") Regardless of the controversial participation of Beelzebub in all this, words, those malleable inhabitants of our social space, far from being pristine (from the Latin pristinus, "ancient," derives its current meaning of "innocent", i.e., "uncorrupted by civilization"), are heavily loaded by context. Words meanings, therefore, shifts with shifts in context. Further, words carry families of meanings, as they resonate with their synonyms—why did we chose this and not that word to refer to a given event, or object, or person?--, their

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antonyms—what is the opposite meaning that this words reminds us as a contrast (sometimes a mirror counter-image that bites the tail of the original word)?--, their associative chains—what other utterances come to mind paired to this word?--, their ethical resonance—what moral order do they evoke?--, their instructive component—what do they hint us to do, or to not do?--, and their emotional context—what passion do they evoke, what memory?

Allow me to share the result of my armchair incursion into the wilderness of semantics and some musing that derived from it ("musing", by the way shows two possible Latin etymological roots: "To meditate inspired by the Muses", or "To loiter." You, the reader, will have to decide which applies here.)

The word **consumer** derives from the Latin composite *cum-sumere*, that is, to use up, to take up wholly. (DEL, DME) In its twentieth century usage, a "customer or a patron is a buyer, someone who purchases something from another." (DPWE) When exploring its synonyms, we find "user, buyer, purchaser... vendee, emptor; shopper, marketer; customer, client, patron, patronizer, regular, Fr. habitué" (SF) But, already in the 1987 edition of RHD, "1.a person or thing that consumes; 2. Econ. A person or organization that uses a commodity or service."

"Aha! 'A person who uses a service' fits the current meaning of 'consumer' in the lingo of health," we could rush to propose. Even further, we could argue that the usage of that word has been inspired by the noblest of contexts, the socially responsible Consumerism movement, namely "A modern movement for the protection of the consumers against useless, inferior, or dangerous products, misleading advertisement, unfair pricing, etc...." (RHD) (Please also cf. Frank's, 2000 lucid article on the subject in the above mentioned issue of this very journal.) That movement not only advocated in behalf of the weak, the helpless, and the suckers, but championed their cause by actively defending them. For that purpose, it created the role of the *consumerist*, "also called *consumer advocate*, a person who is dedicated to protecting and promoting the welfare and rights of the consumers. ..." (RHD)

However, that role and that description, when applied to the field of health, entailed a powerful sleight of hands: it transformed the patient-professional dyad into an unholy triad, as it carries with it the assumption that there is an implicitly dangerous, exploitative relationship between a naïve consumer [“naïve” is the feminine of the French naïf, meaning natural, simple, in turn from the Latin nativus, native], who needs protection by a benign advocate [“benign” derives from the Latin benus, good, and genus, born, that is, “born good” or “born to do good”], against conniving exploiter [“conniving” comes from the Latin cum, together, and niguere, to wink, that is, to signal complicity, or to turn a blind eye.] And who, pray, are the actors that represent these three characters in the current mental health scenario: the (until recently called) patient, the (recently created) managed care representative and the (until recently called) doctor, or professional.

Before exploring who had responsibility of this script, with the inherent debilitating effect of the interest of the benign advocate to maintain his own role—and salary—by maintaining the other two as conniving and as naïve, I would like to add a footnote to the above-mentioned article by Frank (2000). The Consumer Movement had a rather meek presence in the field of mental health, its terrain being already prepared by an accumulation such as that of Clifford Beers' early autobiographic account (1939) of his vicissitudes as psychiatric patient. (Beers, by the way, became years later a president of the American Society for Cybernetics and was, until his recent death, an important icon in its Annual Conferences.) The Consumers Movement expanded exponentially thanks to the ferment of the Civil Rights movement, and gained added strength with the romantic anti-psychiatric discourse of the '60s and the widespread consumer empowerment of the '70s. In the field of mental health the most visible exponent of that movement has been the National Alliance for the Mentally Ill (NAMI), founded in 1979 as a grass-root coalition of patients and families of patients diagnosed with schizophrenia. The basic ideological guidelines of that organization, as it profiled in the past fifteen years, have been that schizophrenia

is a brain disease, genetic in origin, with families playing no role in its development or maintenance, and amenable only to biological and educational treatment (Cf., e.g., Mosher and Burti, 1989). NAMI was in its origins reacting reasonably to the family bashing experienced by relatives of patients with schizophrenia exposed to professionals' behavior congruent with the dominant psychoanalytically oriented approach that was dominant in the psychiatry of the '60s and early '70s. Closer to home, family therapy approaches were equally family blaming, at least until the message of the psycho-educational approaches helped us to think otherwise. To that family-as-a-cause-of-the-problem ideology NAMI countered by espousing a biology-is-all, disease ideology. In its quest, NAMI found staunch allies in the powerful biologically oriented contingent of the traditional psychiatrists' organizations. ("Staunch," originating in the Latin stagnare, "stopping the flow of blood", moved from the healing arts to the nautical world, with the meaning "water tight", and then to the metaphoric realm of "tight," as is its current use)

Another unexpected and generous ally of NAMI has been the most profitable — and tax-wise heavily sheltered-- industry in the United States (Angell, 2000), the pharmaceutical industry. The drug industry provided and continues to provide generous subsidies to NAMI—which, not surprisingly, became a powerful lobby advocating a biological focus for mental health practices. To complete the circle, the pharmaceutical industry also subsidized the main psychiatric organizations until they became addicted to that subsidy. In fact, currently, neither the American Psychiatric Association's Annual Meetings or NAMI's infrastructure itself could survive without the drug industry's subsidies. The pharmaceutical companies, in addition, have become the major economic supporter and, in many cases, the actual shadow creators, of a variety of currently mushrooming organizations that are, or appear to be, consumer-oriented. All these organizations voice a biologically-oriented approach to the understanding and treatment of schizophrenia, depression, obsessions-compulsions, phobias, PTSD, and you name it. Not surprisingly, all those seemingly grass-root organizations have adopted a biologically oriented

ideology and are strong supporters of pharmacological treatments of most psychiatric disorders (for which psychotropic drugs have been revolutionary)... and most human foibles ("foibles" was in its origins a mispronunciation of the French faible, "weak.")

An ideological disclaimer of this author is in order here. I am a strong supporter of the consumerist movement in the fields of health and mental health—we professionals need patients' watchdog organizations to keep us clean, focused, and less arrogant. I have been a supporter of NAMI in word and action (and even a proud recipient of an "Exemplary Psychiatrist" Award from that organization.) I am also in support of guild organizations, each one caring for the wellbeing of its professional members. What I am highlighting here is an unholy alliance of those organizations with the pharmaceutical industry, which has strongly polarized with its own benefit-based ideology both the consumer's movement and many professional organization. As another, rather fatalistic, Spanish proverb goes: "*Dios los cria, y ellos se juntan*" (God creates them and they manage to find each other).

The picture of this complex reality should be further muddled by adding a third, even more powerful, economic group that has been playing an increasingly center-stage role in the field of health, namely, the insurance industry and their representatives or partners, the managed care companies. For the record, managed care companies are for-profit concerns explicitly aimed at reducing expenses by controlling the nature of the doctor-patient, or health care specialist-customer, relationship, governing at the distance not only the economic side of that relationship—as they arguably are supposed to do--, but the very nature of it ². At the service of this task, the managed care industry has

² According to an unpublished but widely cited managed care outcome study by Rosenheck et al., at Yale University (cf. DHHS/NIH, 1998), managed care has been able to reduce the utilization of mental health services by 44%, but, at the same time, that population increased absenteeism by 22% and utilization of medical services by 36%, offsetting any actuary benefit. There are other studies of the effect of managed care, but most of them have been paid for or controlled by that industry itself, and therefore cannot be taken at face value.

been the main—and rather successful-- pusher for the use currently in vogue of the word “provider,” a term that encompasses generically all those who interact professionally with a consumer of health care services, namely, the patients or clients.

The word **provider** is, meaning-wise, rather fuzzy. It has its roots in the Latin providere (before-see) to foresee [hence Providence but also provision--referring to eatables—and, indeed, provisional.] (DEL, DME) Its synonyms are rather telling: “1. Supporter,...head of household, breadwinner...Informal: one who brings home the bacon. 2. Patron, giver, donor, contributor, backer, funder, angel, bestower... Informal: Sugar daddy. 3. Supplier, furnisher, procurer, purveyor, provisioner, caterer.” (SF)

What could be the interest of the managed care industry in favoring the new meaning of the word, namely, “all those who provide services to patients.” I can see only one answer: to de-differentiating the different professions within the health team, blurring the inter-professional boundaries—regardless of how much they overlap (and hence making them amenable to cross-disciplinary collaboration). And the reason is that it is in the best interest of their executives and stockholders to save money by (a) reducing payment for everybody's professional service; and (b) reduce the role of the most costly professionals, loading, if unavoidable, the lower cost professionals with activities carried on before by the most costly professionals. “Most costly” means here MDs, and “less costly” means nurse practitioners, marriage and family therapists, and social workers, with psychologists inhabiting an intermediate zone. The reason is purely economical—and not in the actuary sense of a rational organization of health care, but in the more blatant one of the managed care industry making money to their own for-profit coffers.

Another word has competed timidly with “customers” in the semantic market, and it is the word “client.” In fact, some members of an interdisciplinary team—especially those clinicians without a doctorate, such as the MFTs-- may prefer to

refer to people who consult with them as “clients” rather than “patients”: the word “patient” evokes in the public mind the complementary word “doctor.” And while there are colleagues with a doctorate in nursing, in social work, and in psychology, still the word “doctor”—“anyone who has been granted a doctor’s degree” (DPWE)—evokes in the public the image of a MD. In fact, the word **doctor** derives from the Latin docere, to teach, and was originally applied to great schoolmen— St. Thomas Aquinas, for instance, was called Doctor Angelicus—, but since middle ages has been used to refer mainly to the doctors in medicine. (DME) **Client** has been used to refer to “1. A person or group that uses the professional advice or services of a lawyer, accountant, advertising agent, architect, etc. 2. A person who is receiving the benefits, services, etc., of a social welfare agency, a government bureau, etc.; 3. A customer. ...” (RHD) (DPWE) Its synonyms expand the collage: “1. Customer, patron, patronizer, regular, ...buyer, purchaser. 2. Dependent, follower, protégé, student, pupil, disciple, attendant, supporter, backer, adherent.” (SF) While potentially evoking a variety of association utterly unrelated to the healing practices, there is nothing in that word’s resonance’s that would lead to question its use. In fact, “client” comes from the Latin cluere, to listen—originally, one who listens to advice, in turn derived from the Greek “to hear” [an alternative etymological hypothesis relates it to clinare, to lean, such as in “inclination,” to lean toward]. (DEL, DME) It could be argued, hence, that, for the sake of the team harmony in interdisciplinary practices, we may chose to transform patients into clients.

However, when nobody is listening, I will still refer the people who consult me professionally as patients. After all, **patient** is “ A person who undergoes medical care or treatment. ...” (RHD) (“Patient” derives from the Latin pati, to suffer. The patient is he or she who sufferers. (DEL, DME) Browsing into its family of synonyms, we can find “sick or ill person, infirm person, hospital case, case; asylum inmate, convalescent, outpatient, shut-in, valetudinarian; sufferer, victim.” Other associations of the word “patient” or “patience” leads us to the sets enduring/ stoical; serene/ placid, and tenacious/ unremitting. (SF))

Summarizing, "patient" may be the most appropriate word to refer to those who consult us for reasons of dis-ease. It can be questioned mainly in terms of its evoking the guild-based, perhaps potentially exclusionary, notion of "doctor" in the sense of "MD". "Client," in turn, may to evoke a strange mix of "adviser", "seller" and "guru", but may be more palatable for the different members of an interdisciplinary practice. But both terms, patient and client, appear to risk extinction, vacated by the new terminology pushed by the managed care/insurance industry and the other forces discussed above. And that brings me back to the subtitle of latest issue of this very journal. By accepting that term, we may find ourselves sliding into a slipper slope, co-opted by the insurance/managed care multi-billion dollars industry, by the pharmaceutical multi-billion dollars industry, and by the guild interests of the lower-end (in the sense of less years of post-secondary education, and comparatively more poorly paid) of the spectrum of mental health providers.

The argument adopted by the insurance/managed care industry and by many politicians is that the finite pie of health expenditures is excessive, and growing. Well, if we expand our view to obtain a broad point of comparison, the US, 2nd among all developed nations in terms of GDP Index (the #1 is tiny Luxembourg) and 1st in terms of % of GNP devoted to military expenditures, ranks 23^d in terms of life expectancy at birth, 27th in terms of infant mortality rate. And, as a coup de grace, comparing this time only the 15 most developed nations, the US ranks 7th in terms of percentage of GNP spent on health (UNDP, 2000.) In fact, and against the tapestry of the unprecedented profit of both the pharmaceutical and the insurance industry, the quality of care and of services in the US continues to erode and the gap (a word of Icelandic origin, meaning abyss) between services for the wealthy and insured and for the poor and uninsured continues to increase.

There is something in this picture that should make us feel uneasy, were we not protected by distorting terms that manage to keep things out of focus. Remaining complacent with terms loaded by the Devil contributes to maintain

the veil of mystification that helps us not to see [which, by the way, is a modern concoction from the Greek mytos and de Latin ficare, that is fable-making.](DEL)

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