**The Issue Is**

Client or Patient: Which Term is More Appropriate for Use in Occupational Therapy?

Words are powerful tools; they have the power to affect perceptions, attitudes, and actions. The decision about whether to refer to persons who use occupational therapy services as clients or as patients is an important one. Sharrott and Yerxa (1985) and Reilly (1984) discussed this issue and concluded that the term patient is the better choice. Reilly approached this topic from the standpoint that "the tendency for our official language to refer to an occupational therapy client rather than an occupational therapy patient reached an obvious consensus by 1983" (p. 404). Neither term, however, seems to be universally accepted. In the December 1987 issue of the American Journal of Occupational Therapy, for example, although most of the articles discussed patients, a significant number mentioned clients. What is more distressing, however, is the number of articles that use the two terms interchangeably. These terms have strong connotations; we are conveying mixed messages and, thus, being unfair to occupational therapists and to the general public by using both terms. This discussion is relevant not only to occupational therapy but to all of the health care professions.

**Definitions**

Sharrott and Yerxa (1985) quoted from Webster's Seventh New Collegiate Dictionary in defining these two terms. They wrote that a patient is "an individual awaiting or under medical care and treatment" (p. 401), neglecting to mention that patient is also defined as "one that is acted upon" (Webster's, 1972, p. 618). A client is "a person under the protection of another; vassal, dependent" or "a patron or customer" (Sharrott & Yerxa, 1985, p. 401). Again, Sharrott and Yerxa left out the additional definition; a client is a "person who engages the professional services of another" (Webster's, 1972, p. 155). The implication of the definitions that were ignored is obvious; a patient is a passive recipient of treatment, whereas a client plays an active role in seeking out professional help. In addition, the definition of a patient as one who is awaiting or receiving medical care bypasses an important aspect of occupational therapy, which is that occupational therapists work not only with illness but also in the areas of prevention and maintenance. The term patient, then, seems insufficient at best.

It is especially in the area of mental health that this point becomes clear. Persons receiving occupational therapy in a setting such as a community mental health center are not necessarily sick. To label them as such may lead to unwarranted stigmatization as well as an undermining of the therapeutic relationship.

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**Moral and Economic Implications**

Sharrott and Yerxa (1985) derived from their selected definitions that patient is associated with medical care, whereas client conveys an economic relationship. They wrote that in adopting client over patient, "we are changing our relationship with the person served from one based on a moral-ethical tradition (patient) to one having an economic-legalistic foundation (client)" (Sharrott & Yerxa, 1985, p. 401). They were not the first to bring forth this point; Reilly (1984) also mentioned it in her discussion of this issue. This logic, however, seems faulty. True, the medical profession demands a commitment to morality, to giving the recipient of services the best treatment possible. In taking the Hippocratic oath, every physician swears that he or she "will give no deadly drug to any, though it be asked of me" (Encyclopaedia Britannica, 1957, p. 197). The term client, however, although implying an economic-legalistic foundation, does not preclude a moral-ethical tradition. The emphasis may differ, but a professional serving a client has a moral obligation, often supported by legislation, to provide the best service possible. For example, the judicial system is both a legalistic and a moral-ethical system. A lawyer, part of a legalistic institution that deals with clients, is obligated "to represent his client zealously within the bounds of the law" (McKinney's, 1975, p. 466); any lawyer not doing so risks disbarment. The definition given in Webster's (1972) is again relevant. A client is "under the protection of another" (p. 155), not at the other's mercy. In fact,
persons receiving occupational therapy are legally protected against lack of proper care. Professional misconduct by an occupational therapist (e.g., fraudulent obtaining of a license) is subject to penalty (McKinney, 1985). The fear that moral actions will disappear with the use of the word client is irrational; moral actions are supported and reinforced by the existing legal code.

Rights and Just Claims
Sharrott and Yerxa (1985) claimed that the use of the word client indicates a shift not only to an economy-based medical ethic but also to a rights-based ethic. They deemed this change, claiming it to be "supremely incompatible with the philosophy of occupational therapy, that of moral treatment" (p. 402). Although the term client may imply an economic-legalistic approach, we cannot assume that this approach to occupational therapy is equivalent to a rights-based approach. Yet, even if the approaches were synonymous, the result does not appear to be negative. Sharrott and Yerxa quoted Webster's Seventh New Collegiate Dictionary in defining right as "something to which one has a just claim" (p. 401). A system based on this definition, in which anyone needing medical treatment is entitled to receive it, is certainly compatible with the philosophy of moral treatment inherent in occupational therapy.

Elisabeth Kübler-Ross (1969) addressed the topic of just claims when she deplored the fact that the rights of the patient are often overlooked:

"When a patient is severely ill, he is often treated like a person with no right to an opinion... It would take so little to remember that the sick person too has feelings, has wishes and opinions, and has most important of all, the right to be heard." (p. 8)

The patient, as the passive recipient of health services, cannot claim this right. The client, however, has the right to demand information about treatment and is free to voice opinions. The term client, therefore, is more appropriate for use in occupational therapy and should be seriously considered for use in other health care professions as well.

The client's possession of certain rights allows him or her to retain a certain amount of control. The person receiving medical treatment, especially in a hospital, often feels a lack of control over the dysfunction or the environment. This feeling can lead to hopelessness and helplessness, neither of which is therapeutic. If the person is treated as a client and is allowed to make certain choices about the health care process, however, he or she can maintain a feeling of control. Heim et al. (1982), in their discussion of burn management, wrote that "when loss of self-control and autonomy become issues for patients, they should be allowed to share in decisions about their treatments and daily activities whenever possible" (p. 12). Yet why should this participation be delayed until problems of self-control and autonomy manifest themselves? By allowing the client to exercise the right of choice from the start of treatment, we can help prevent these issues from arising.

Kübler-Ross (1969) emphasized the person's right to obtain correct information about his or her medical condition directly from the health care professionals themselves. She believed that the physician or therapist should not hesitate to tell the person the exact nature of the illness. As she phrased it, "the question should not be stated, 'Do I tell my patient?' but should be rephrased as, 'How do I share this knowledge with my patient?'" (p. 32).

The rights that Kübler-Ross mentioned encompass an important aspect in health care—that of respect for the individual. The passive patient, often addressed by first name and left partially exposed by a skimpy hospital gown, feels demeaned. Conversely, the client who exercises the aforementioned rights can demand the respect to which all persons are entitled but might otherwise not receive. In occupational therapy, as in all other health care professions, we must recognize the individual in this light and prevent the dehumanization that is otherwise inevitable.

Heschel's words convey not only the importance of our using the correct terms but also the necessity of our understanding and being sensitive to words. Heschel, however, believed that the term client should not be used. He thought that "the patient must not be defined as a client who contracts a physician for service" (p. 31). Yet his decision to use the term patient was directly related to his view of the health care provider as omnipotent and omnipresent and of the health care recipient as utterly powerless. "The doctor's role is one of royal authority, while the patient's mood is one of anxiety and helplessness" (p. 31). Although Heschel exhibited a sensitivity to language by imposing a specific meaning through his choice of terms, this meaning is antithetical to the values of respect, knowledge, responsibility, and participation. The lack of these values, compounded by a misuse of terms, can lead to dehumanization.

Social Responsibility
Sharrott and Yerxa (1985) feared that dehumanization would arise as more hospitals refer to the persons they serve as clients and as they join corporations as an economic measure:

"As health care is increasingly placed in the hands of business-minded administrators, moral obligation is lost in the sheaves of computer printouts recording profits and losses." (p. 403)

Most hospitals are already so large that the administrators have no contact with the patients. It is too late to bemoan this loss of the personal touch; instead, we must make sure that hospitals are run efficiently. "Without a profit or surplus, no hospital could update equipment, modernize units or meet emergencies" (Mershon, 1986, p. 243). Without profits, everyone will suffer. The question, therefore, should not be whether it is ethical for hospitals to be concerned with profits, but
whether it is ethical for them not to be so concerned. "A hospital's social responsibility includes remaining financially stable" (Mershon, 1986, p. 242).

Sharrott and Yerxa (1985) worried that in a client-based system only those persons who can afford to pay for health care services will be able to receive them. Yet, this problem already exists to a great degree within the patient-based system. According to a 1983 survey, 15% of Americans (35 million people) do not have health insurance of any kind (Jomis, 1986). The refusal to use the term client is not going to solve this problem. Indeed, it is the responsibility of the state or federal government, not of the health care provider, to provide solutions to the problem of health care for those who cannot afford it. "The problem is society's problem and not the provider's problem any more than hunger is the grocer's problem or housing is the realtor's problem" (Mershon, 1986, p. 244).

Advocacy

In continuing their argument against the use of the word client, Sharrott and Yerxa (1985) claimed that this legalistic relationship would require that the person seeking occupational therapy must be "a competent adult capable of self-directed choice" (p. 402). They claimed that persons with cognitive or emotional disabilities may be unable to make rational choices and therefore may be unable to obtain services. This claim, however, is not necessarily true. Under New York State law, a person who is unable to make competent choices is placed under the care of another who can make these choices with the client's best interests in mind:

When it shall appear to the satisfaction of the court that a person is incapable of managing himself and/or his affairs . . . who requires in his best interest the appointment of a guardian of the person or of the property or of both, the court is authorized and empowered to appoint such guardian . . . " (McKinney's, 1988, p. 26)

The law recognizes the inability of some individuals to make appropriate choices and has provided for this contingency with the appointment of an advocate. Thus, Sharrott and Yerxa's fear that a client-therapist relationship precludes advocacy is unfounded. Reilly (1984) believed that "a therapist cannot treat a client; the relationship is illegitimate" (p. 405). Her reasoning is unclear. A therapist, according to Webster's (1972), is "a person trained in methods (as occupational or physical) of treatment other than the use of drugs or surgery" (p. 916). The use of drugs or surgery implies a situation in which one is acted upon, which is one of the characteristics of a patient. Because therapists use neither drugs nor surgery and generally engage the participation of those receiving the services, the use of the term client seems quite appropriate.

Sharrott and Yerxa (1985) quoted Adolph Meyer's philosophy of occupational therapy to give additional support to their position. Meyer (1977) stated that "our role consists in giving opportunities rather than prescriptions" (p. 641). Sharrott and Yerxa believed that Meyer's statement about giving opportunities somehow implied acting morally and thus referred to one's dealing with patients. However, his statement suggests just the opposite. A patient is one who is acted upon, told what to do (e.g., one prescribes medicine to a patient). A client, however, is one who actively seeks help— one who would be the first to seize the opportunities offered by occupational therapists.

Finally, Sharrott and Yerxa (1985) said that "a client-based service is not likely to be understood or valued by society" (p. 404). The opposite is true, however. The capitalistic society in which we live is oriented toward seeking the best professional services available for payment rendered. Why else would investment bankers and lawyers be among the highest paid professionals in the nation? The client-professional relationship is one that is well understood and well respected.

Conclusion

The term patient is not the best choice for use in occupational therapy. Because the word implies that the person receiving treatment is sick, it precludes the use of occupational therapy in the areas of prevention and maintenance. Additionally, in the realm of mental health, the word patient unnecessarily stigmatizes the person receiving professional services. In all cases, patient undermines the therapeutic relationship by implying total passivity of the service recipient and omniscience of the service provider.

The term client is the best choice for the identification of the recipients of occupational therapy services. A client can take an active part in the therapy process and assume some measure of responsibility for progress. A client can learn what to expect and can rightly demand quality treatment for payment rendered. The economic-legalistic implications of the word client mean not only that the health care system can attain the revenues to continually provide quality care but also that this care is guaranteed by legislation. The client-therapist relationship, therefore, assumes a mutual respect.

One may argue that at times an individual is a patient, that is, unable to actively participate in the therapeutic process. It is especially at such times that the therapists must take the responsibility of treating the person with respect, of recognizing the rights the person is entitled to but cannot claim. A person who has had a stroke, for example, and consequently has lost the ability to speak or to use one arm, must not be treated like an object. The therapist must take care to explain all procedures to this person, even if there is no verbal response. For the person whose brain function is minimal, the body must be treated with respect even if the mind cannot appreciate it.

Although choosing to use the term client over patient is important, the change in usage itself is not enough. The word's implications and the rights and privileges associated with it must be considered constantly. It is only when occupational therapists and the public keep in mind an understanding and appreciation for the term client that the ideal therapeutic relationship can be attained.
References


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