The Customer Approach to Patiency

Attending to Patient Requests in a Walk-In Clinic

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This report conceptualizes the initial psychiatric interview as a process of negotiation between the clinician and patient. Patients are perceived of as appearing with one or more requests, many of which represent legitimate needs. It is the clinician's task to elicit the request, collect the relevant clinical data, and enter into a "negotiation" that should foster a relationship of mutual influence between patient and clinician.

We have attempted to show that this approach to patience not only improves patient care and patient satisfaction but also leads to improved staff morale. The "customer approach" has special relevance to those clinical settings (walk-in clinics and community mental health centers) in which clinicians see a broad range of patients with a broad definition of psychiatric problems and requests.

It is a frustrating and fatiguing experience to treat patients and teach personnel in a busy walk-in clinic. Large numbers of patients want immediate help with a heterogeneous group of problems that do not easily lend themselves to official diagnostic categories or psychodynamic formulations. As a result, the clinician is always in danger of feeling drained and helpless. The psychotherapy clinic and the inpatient unit, in contrast, are able to screen their admissions for the proper number and kind of patients for whom they have developed treatment programs. There is at least some consensus as to the outpatient treatment of the neuroses and the hospital management of the psychoses.

Frustration with the numbers of patients and the kinds of problems they have may be dealt with in various non-productive ways. On a departmental basis, the clinic may be relegated to second-class status by limiting staffing and teaching allocations. The clinic staff may cope by discouraging patients with excessive delays in the waiting room, by providing such brief therapy that it is inadequate therapy, or by playing "musical clinics," referring large numbers of patients to another facility that, in turn, makes an additional referral.

Despite the frustrations and fatigue, we have come to believe in the special importance of the walk-in unit as a clinical service and as a place to train psychiatric personnel because it represents general psychiatry. Psychotherapy and inpatient care, like cardiology and intensive care, are subspecialties. Given this special importance, there is a need to reconceptualize and reorganize ideas around the walk-in patient so that patient care and staff morale are improved.

In 1969, with the incentive of having to provide a meaningful training experience for first-year residents in a walk-in clinic of a general hospital, we set out to learn from patients what they wanted from the professionals who were there to serve them. Based on these observations and on subsequent research, we have been evolving the "customer approach to patience."

This approach is an attempt to conceptualize the initial interview as a process of negotiation between the clinician and the patient, taking the patient's request as a starting point. Most patients make one or more requests, many of which represent legitimate needs. These requests or needs include those for long-term psychotherapy, psychiatric diagnoses and treatment, and many others. It is the clinician's task to elicit the patient's request, collect the relevant clinical data, and enter into a "negotiation." As a result, it is hoped that the patient will feel his perceived needs have been heard and responded to while the clinician will feel that he has been not only comprehensive but responsive to the patient. The negotiation should facilitate a relationship of mutual influence between clinician and patient to the benefit of both parties.

The initial interview as a negotiation is an elaboration of an idea described earlier by Levinson et al. In this important report, they contrast the "negotiated consensus" with both the "suitability" and the "diagnostic" approaches to patience. Using the "suitability approach," the clinic screens the patient to determine whether or not he fulfills the criteria to become "a good therapy case." Here the patient must have the credentials (ie, young, verbal, and motivated) to be offered the treatment the clinic is offering. Using the "diagnostic approach," the clinic determines on the basis of observable signs and symptoms whether or not the patient is suffering from a psychiatric illness. Many of the problems in providing service in a walk-in clinic, we believe, result from the inappropriate use of suitability or diagnostic approaches previously described.

In this report, we will describe the customer approach, its implementation, and its clinical importance. We will attempt to show that this approach to patience not only improves patient care and patient satisfaction but also leads to improved staff morale.

IMPLEMENTATION OF THE CUSTOMER APPROACH
Patient Requests

The negotiation process between the patient (or prospective patient) and the clinician rests on the assumption that the patient has something in mind that he wants. To the surprise of many clinicians, the vast majority of patients who come to the walk-in clinic on their own volition know with considerable specificity how they would like the

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clinician to intervene on their behalf.

From our analysis of several hundred interviews, we were able to classify patient requests into the following 15 categories: administrative request, advice, clarification, community triage, confession, control, limit setting, medical, psychological expertise, psychotherapy, social intervention, reality contact, succorance, ventilation, and nothing. The definitions of the request categories are reported elsewhere. We have attempted to describe them in terms that are meaningful to both clinician and patient and that lend themselves to therapeutic intervention.

We have recently developed a 75-item questionnaire, the Patient Request Form (PRF), to measure requests in these 15 categories. Using this instrument, we have demonstrated by factor analytic techniques the mathematical independence of most of these request categories and have described the frequency with which patients make particular requests in a walk-in clinic.

Since clinicians, after learning the patient's complaint (chief complaint) or the patient's goals, often believe they know the patient's request, it is worth distinguishing the three. The complaint is the patient's initial statement as to what is bothering him; for instance, "I am depressed." The goal is what the patient would like to accomplish or how he would like to feel; for instance, "I would like to feel well enough to return to work." It is the goal that is the basis of the "contract" of Transactional Analysis. The request is how the patient would like the clinician to respond to help him achieve the desired goal. He might request clarification: "Help me understand the reasons why." He might request social intervention: "Tell my family to stop degrading me." He might request medical intervention: "Give me something for my nerves." He might make an administrative request: "Would you write a letter to my draft board?" In our studies of initial interviews, we have found that the complaint is invariably elicited, the goal is usually elicited, and the request is often not elicited. Clearly, the negotiation process will be seriously impaired if the clinician does not know the patient request.

Elicitation of the Patient Request

Since the patient's statement of the request during the initial interview is a critical beginning of the customer approach, how the clinician elicits the request deserves special attention.

Sometimes the patient will state his request spontaneously at the beginning of the interview. When this does not occur, the patient request is best elicited after the clinician learns the patient's complaint and a meaningful part of the present illness. This preliminary interaction establishes the rapport necessary for the elicitation of the patient request that turns out to be a most intimate revelation. Eliciting the request at the very start of the interview before the patient has stated his problem increases the chances of placing the patient in the position of adversary rather than collaborator in the diagnostic and therapeutic process. "You asked me what I want. You do not even know what is wrong with me." Eliciting the request at the end of the interview deprivs the clinician of the opportunity to negotiate or work with the request.

We have been most successful in eliciting the patient request by asking, "How do you hope (or wish) I (or the clinic) can help?" The questions "What do you want?" or "What do you expect?" should be avoided since they are likely to be perceived as a confrontation. The words "wish" or "hope," in contrast, give the patient permission to state requests he does not necessarily expect will be granted. Even when the clinician finally asks the patient what he hopes for, the response is commonly, "I don't know. You are the therapist," or "I just want to feel better." In this kind of situation, the patient frequently has a rather specific request in mind that he is reluctant to state for reasons we will describe later. The elicitation of the request then requires persistence, persuasion, and compassion. "You must have had some idea when you decided to come," or "It is important for me to know what your wishes are even if I may not be able to fulfill them."

The initial statement of the request may be incomplete or stated in such general terms that it requires elaboration to achieve the specificity necessary for clinical utility. "You said you want me to help you understand things better. What in particular do you want to understand?" or "You thought you would feel better if I would fix up your family situation. How do you hope I can fix it up?" When the request has finally been stated and elaborated, it is important that the clinician acknowledge that he has heard and understood the request. Otherwise, the patient may wonder whether the clinician heard the request, was offended by it, or didn't believe it worthy of a response.

The elicitation of the request undoubtedly depends on more than timing and phraseology. Certainly, the clinician's attitude of interest and receptivity is crucial. We have observed, for instance, that the patient frequently hints at or alludes to the request apparently waiting for some response from the clinician that will indicate that it is acceptable to continue or to become more specific.

As the interview proceeds, the clinician should listen for elaborations of or changes in the request resulting from the developing relationship between clinician and patient. The patient thinks to himself, "Now that I have more trust in you, let me tell you what I really want," or "Now that you have responded to my initial request, it occurs to me that there is something more important that I need."

Negotiation and Disposition of the Patient Request

What we refer to as "negotiation" is the heart of the clinical process. It is the coming together, the interaction, the dialogue between the patient who is formulating what he thinks he needs and the clinician who is formulating what he thinks is clinically appropriate. In an ideal negotiation, the patient exerts his influence in several ways. First, since the request has considerable diagnostic value (see CLINICAL IMPLICATIONS), the patient is providing the clinician with valuable information. Second, the statement of the request itself obliges the clinician to consider the legitimacy of the perceived need and to explain why an alternative formulation might be more valid. Third, the patient has the right to evaluate and ultimately accept or reject any treatment proposal. In the process, he may expect to receive from the clinician an additional explanation, an alternative treatment plan, or a statement
that the clinic cannot meet his request.

The clinician is simultaneously exerting his influence by the clarification and evaluation of each request in regard to whether or not it is clinically appropriate, clinically sufficient, and clinically feasible. If a request is clinically inappropriate, such as a request for medications where there is little likelihood that medications will be effective or a request by a manic patient for psychoanalysis, the clinician attempts to educate the patient so that he will change his request.

It is not uncommon for the request to be appropriate, but not sufficient. For example, the patient who wants to talk out his upset feelings about his failing memory undoubtedly has a legitimate request, but he also may need a neurological evaluation. For the patient who on repeated occasions asks the clinic to intervene in repetitious social situations, the clinician might consider with the patient how he contributes to his own problem.

Where the request is clinically appropriate but not clinically feasible because of the limitations of the treatment facility, such as a scarcity of psychotherapy time or the absence of a laboratory to measure blood lithium ion levels, this dilemma should be stated directly and honestly to the patient. At least the patient has received clinical confirmation of what he needs and can be referred elsewhere.

Impasses in negotiations are common and remedial strategies are varied. It may be helpful to understand the patient’s theory as to the nature of his illness and to inquire what he has tried before. It may help to know the patient’s fears about his “illness” and what he specifically does not want to happen. It may be helpful for the clinician to restate his formulation in the patient’s terminology in order to facilitate communication. Where the clinical picture represents a discrete syndrome, such as some of the affective disorders, the clinician’s describing the syndrome, its course, and treatment often influences the patient to accept what is needed. The clinician may influence a patient to accept a recommendation for psychotherapy by helping him understand the psychotherapeutic process. This may be facilitated by showing the patient how he unnecessarily contributes to his own suffering or by helping him experience some painful feelings associated with key psychological issues.

REPORT OF CASES

Clinical Implications

The following six cases are presented to illustrate additionally the customer approach and its clinical implications.

CASE 1.—A 40-year-old woman, whose chart referred to her condition as “chronic schizophrenia,” was referred to the psychiatry clinic from the medical clinic where she stated her problem as “noise pollution.” From her facial expression, her bizarre thought content, and the history of multiple state hospitalizations, it seemed highly probable that the diagnosis was correct. It was also noted that she had been to our clinic several times. Each time she was referred back to her local mental health center. Now, much to our embarrassment, she came to our medical clinic. The diagnosis, the history, and the manner of presentation made the clinician feel helpless and angry. He knew she was ill and that he was expected to help. He believed he had nothing to offer.

After 15 minutes of a rambling, circuitous interview, the clinician asked in frustration how she hoped he could help. She requested to be put “on a stronger pill.” The patient was receiving chlorpromazine hydrochloride (Librium) but no antipsychotic medications. The clinician was immediately put at ease since the request was reasonable. He no longer felt helpless. The clinician was then able to explore how the patient’s daughter, now 13 years of age, was beginning to talk too much and too loudly. This situation seemed to coincide with the onset of the delusion about noise pollution. In addition to a change in medication, the patient was willing to accept the recommendation for a supportive relationship to help her deal with the psychological demands of the adolescent daughter.

The patient concluded by explaining that she was no longer accepting our referrals to her local mental health center because they hospitalized her before listening to her. She came to our medical clinic because she felt the psychiatry clinic, before today, had not listened to her either.

CASE 2.—A 27-year-old man had the target complaint of “nerves . . . too much drinking.” He communicated with considerable urgency his goal of discontinuing drinking and specifically requested pills to accomplish the goal. The clinician, who believed the request was reasonable but failed to share this belief with the patient, proceeded to inquire into other areas that might help explain the drinking. Tension in the interview mounted. Finally the patient angrily responded, “My marriage is okay, my family is okay, everything is okay. . . . Look, I’'ll sing.” With the request clearly stated, the clinician assured the patient that he believed pills were indicated and agreed to write a prescription at the end of the interview. The patient, knowing that his request was heard and would be granted, proceeded to describe his marital difficulties that culminated in his striking his wife. The loss of control was the final event that brought him to the clinic.

CASE 3.—A 55-year-old hospital employee who came to the clinic was interviewed by a psychiatric resident in the presence of three other residents and the senior author. The patient said he was upset and depressed. Some mild depressive symptomatology was indeed elicited. He also explained that he was troubled by his wife’s recent hospitalization for a recurrent psychotic condition. The resident attempted to understand the depression in terms of his loneliness or his feelings of guilt, or both, but was unable to elicit responses that would support this formulation. The patient’s request was not elicited.

The patient was asked to wait outside the office while the residents conferred about possible treatment options. Psychotherapy and pharmacological treatments were considered. It was decided that the request should first be elicited.

In response to the question “How did you wish we could help?” the patient replied, “I work here in the hospital kitchen and bring food up to the psychiatry ward. It’s a nice clean place and they treat the patients well. If you have space, would you call the state hospital and have her transferred? I would feel much better.” The transfer was arranged and the patient became asymptomatic.

CASE 4.—A 42-year-old divorced woman came to the clinic and stated the following: “My house burned down two days ago. I need something for myself; I need pills for my nerves.” The patient was given the opportunity to tell her story for the next 30 minutes. She seemed to use the time for ventilation, emotionally recounting in considerable detail the description of the fire. The clinician’s supportive listening was a response to the first part of the patient’s request for “something for myself.” The clinician could then respond to the second part of the request with, “I don’t believe pills are necessary.” The patient replied, “I agree with you. I’m feeling so much better already. Could you give me your name and phone number so I can call you and let you know how things work out?”

CASE 5.—An unkempt 46-year-old chronic alcoholic man, smelling of alcohol but not acutely intoxicated, was guarded during the
first few minutes of the interview as he tried to sense whether or not he would receive the unfriendly welcome often given the alcoholic patient. As he began to feel that the clinician was interested in finding out what was bothering him and what he wanted, he proceeded to tell his story. Born in Scotland, he had only one relative in this country, a sister living in Baltimore. The patient had lost contact with her when she was hospitalized eight months ago. He could never muster the nerve to call for fear of learning of her death. His request of the clinician was for social intervention: "Would you phone her for me? Here is $2.30." The clinician made the call and successfully put him back in contact with his only relative. (An implicit request was for the clinician to be with him if he learned of his sister's death.) The patient then told the clinician that his visit today was triggered by his bringing his only companion into the hospital for cirrhosis.

As the clinician heard the story, he considered and ruled out the possibility that the patient was suffering from impending delirium tremens, Wernicke encephalopathy, or another condition that would have required some "negotiation" over necessary medical treatment.

CASE 6—A 28-year-old single woman came for help because of depression that was impairing her capacity to concentrate at work. The depression followed her rejection by a married man, 15 years her senior, whom she had felt close to for five years. She described this man in terms ("fascinating . . . never understood by his wife") similar to those she used to describe her father whose death she failed to grieve. It became apparent to the clinician that the depression was dynamically related to her unresolved feelings toward her father. The patient, who was bright and insightful, seemed to understand these issues. Near the end of the interview, the clinician elicited the patient request with full anticipation that she would want psychotherapy. Her response was, "Give me pills to make me feel numb." The question immediately arose as to why the patient did not want psychotherapy. This led to a discussion of a traumatic termination of her previous psychotherapy. It was necessary to schedule a second interview to deal with the meaning of the prior termination before the patient would begin to work at her current dilemma.

COMMENT
Diagnostic Issues

The patient's response to the clinician's elicitation of the request provides information that is diagnostic in the broadest sense. Indeed, some diagnostic data may not become apparent—or will be delayed—unless the request is elicited. As a result of this information, the clinical process becomes more efficient and more effective.

There are many clinical situations in which the patient's statement of what he wants is exactly what he needs. Using the customer approach, the clinician has the chance to learn this information early in the interview and profit from the patient's ideas, a commonly ignored source of diagnostic data. In case 1, the patient with a schizophrenic condition wanted and needed stronger medication. This information may have emerged later in the interview. However, in a busy clinic and with a history of frequent nonproductive clinic visits, the patient may have been sent to her local mental health center before being adequately evaluated. In case 2, the patient wanted and needed medication. In case 3, the patient wanted and needed administrative assistance to obtain better care for his wife and to feel that he was doing all that was in his power to help her. If the request were not directly elicited, his needs would never have been known. In case 4, the patient wanted and needed "something for myself." Had this part of the request not been made explicit, the clinician might have administered or withheld medicines without being aware of a more important need. In case 5, the patient wanted and needed someone to put him in contact with his sister and to be available for other supportive needs if it were learned that his sister were dead. Unless the patient felt comfortable enough to make the request, he would have left with his needs unmet. The clinician may have commented, "Just another alcoholic."

When the patient's request is clinically appropriate, making a careful diagnosis of the request can be very important in determining the precise clinical response. Take for example, the requests for ventilation, confession, and reality contact in three separate patients and assume that these requests represent valid clinical needs. An accurate diagnosis of the request or need will lead to three distinct clinical responses. For the patient who needs ventilation, the clinician can best help by taking the role of the interested listener. If he breaks in to make interpretive comments, the patient is likely to tolerate the interruption, ignore the clinician's words, and go on with his story. For the patient who needs confession, the clinician can best help by an attitude and verbal response that puts the deed in a medical or psychological perspective (when the guilt is neurotic) or that (when guilt is real) shows compassion in helping the patient bear the painful feelings. If the clinician were to assume the role of the interested listener (as for ventilation), the patient would take this response as confirmation of his guilt. For the patient who needs reality contact, it may be important for the clinician to actively share his thoughts about what is real. Again, the role of the passive listener might aggravate the condition.

The diagnostic value of the patient request is equally apparent when it seems out of the clinical context of the interview, clinically inappropriate, or when it catches the clinician unaware. If these situations arise, it is likely the clinician was on the wrong track in his interpretation of the complaint. This was the situation in case 3 in which the hospital employee wanted the clinic to arrange for a transfer and in case 6 in which the patient wanted medication to make her feel numb. The interview would have been more efficient and more effective in both these situations if the request had been learned earlier.

The patient's response to the clinician's elicitation of the request may also have special diagnostic meaning when the patient is reluctant to or refuses to state what he wants (see RESISTANCE TO THE CUSTOMER APPROACH). If the clinician pursues the matter, he will often learn important characterological information about the patient. Patients have told us, for instance, that they are not worthy enough to ask for anything, that they are unwilling to commit themselves, or that they will be obligated to give the clinician something in return. Without these responses, exploration of important psychological issues may be delayed.

Process Issues

There is likely to be a great deal of wasted time and energy during an interview in which the patient request
is verbalized either late in the interview or not at all. Instead of speaking freely about the problem, the patient may be preoccupied, wondering whether or not the clinician is kind enough, respectful enough, wise enough, understanding enough, and flexible enough to hear the request: “When will the clinician be ready to hear?” “When will I have the guts to come right out with it?” The clinician, meanwhile, often unaware of these concerns, goes about the business of establishing diagnoses and making treatment recommendations. He does not understand why the patient participates only reluctantly during the interview. On the other hand, when the patient has stated the request early in the interview and feels it has been supportively heard, he is likely to participate more freely and feel more satisfied at the end.

Sometimes the clinician unwittingly discourages the patient from stating his request. One may observe in this situation a sparring between the clinician and the patient. For example, the patient throws out a hint about the request: “I think I may need to be watched over for a time (alluding to a request for hospitalization).” The clinician then changes the subject without acknowledging the request. “Have you had any physical illness recently?” The patient responds with hostility: “I’m just fed up with everything!”

Sometimes the patient, feeling there is no opening, waits until the end of the interview before stating the request: “By the way, would you ...” The clinician now has new and essential data but not enough time to evaluate or act on them. For example, a patient comes to a medical clinic allegedly for a general examination. As he is about to leave the office after the examination, he states the real request: “Doctor, please tell me if I have cancer.” Had the patient made the request earlier and had the clinician perceived the request as legitimate and important, the clinician could have explored the reasons for the patient’s concern and learned what kind of explanation would be most appropriate.

In many clinical situations, acknowledging the request or giving the patient what he asks for satisfies needs that must be met before a healthier request can be made. For instance, patients who first request control, reality contact, or succorance cannot be expected to progress to requests requiring their active collaboration, such as clarification, until the more basic requests are dealt with. In case 2, satisfying the request for medication frees the patient to explore social or psychotherapy requests regarding the marriage. We refer to this process of shifting requests from “sicker” to healthier as progressive. Contrariwise, patients whose initial requests are rejected or not acknowledged may subsequently arrive at a sicker or regressive request. For example, if a request for social intervention is denied, the patient may request control or reality contact. The chronic alcoholic patient, case 5, may have had these needs had his request to phone his sister been denied.

The elicitation of the patient request has, in many situations, an important impact on the clinician that, in turn, affects the entire course of the interview. In case 1, for instance, the clinician’s feeling changed from anger to compassion as he learned he was not helpless and that there was something to do. Similarly, the clinician in case 3, before hearing the request for assistance in transferring his wife to the Massachusetts General Hospital, felt bewildered that neither medical nor psychodynamic formulations explained the patient’s presentation. In case 5, the “incurable chronic alcoholic” became a human being in distress once his request became known.

It is not uncommon for overworked clinicians, often dealing with patient populations culturally different from their own, to believe that the patient wants radical changes in character and symptomatology that are hard to fulfill. The clinician also believes that the patient will expect him to effect these changes and then becomes angry at the patient for having such unreasonable demands. Having the patient state his request undercuts this series of projections, since what the patient wants is almost always more modest than what the clinician had expected. Patients do not want to be different human beings. They want to feel better.

RESISTANCE TO THE CUSTOMER APPROACH

On the face of things, it would appear that the customer approach described above is no more than a psychological conceptualization of common sense or a statement of the obvious. It would seem hard to disagree with the idea that the clinician, after encouraging the patient to say what he wants, should gather more data and then educate and be educated by the patient, so that in the end those requests that are clinically appropriate would be satisfied. We have, nevertheless, observed an extraordinary amount of resistance (not used in the psychoanalytic sense) on the part of clinicians and patients to this approach. It is as if there were a conspiracy between both parties in which the patient agrees not to say what he wants and the clinician agrees not to ask.

Clinicians describe several reasons why they neither elicit nor respond to patient requests. Some believe that from hearing the target complaint and the goal, they know the patient’s request, even though it has not been made explicit. In other words, the clinician is likely to assume that there is a bright, intelligent, insightful person who describes some personality inadequacy wants psychotherapy. Other clinicians believe that patients either cannot verbalize what they want or that the verbalizations are conscious distortions of unconscious processes. For some, the issue of professional norms is at stake. It is feared that the patient will regard the clinician who elicits the patient’s request as not professionally responsible. “You should know; you are the therapist.” Another important issue has to do with authority. In these circumstances, the clinician may believe that asking the patient what he wants is tantamount to turning over the authority for treatment to the patient. But perhaps the most important issues that keep the clinician from finding out how the patient would like him to intervene are those of impotence and helplessness. There is the concern of many of us that eliciting the request will open up a Pandora’s box of unending, overwhelming, and depleting demands that the clinician would rather avoid.

We have observed three major reasons why patients find it difficult to tell the clinician what they want. The
first has to do with the patient’s belief that it is his role to state the problem but not his evaluation of how the help should be provided. The patient, nevertheless, reserves the right to take his business elsewhere if he is not satisfied. The second reason has to do with the patient’s perception of the clinic as the adversary who has the power to say no. As a result, the patient must hint at this request or present it in an indirect way that may maximize his chances of “winning.” The third reason why patients find it difficult to say what they want has to do with a wide range of personality variables that are reflected in feelings of aggression, guilt, humiliation, or uncomfortable intimacy when they ask for something.

CONCLUSIONS

Evidence is accumulating that psychiatric patients and the professionals who serve them are worlds apart. This is especially true for patients of the lower social classes who constitute the major caseload of many hospital clinics and community mental health centers. These patients frequently have goals and expectations of treatment that differ from those of the therapists who treat them. Specifically, the patients of the lower classes want help with symptoms or unpleasant social conditions and they expect the professional to be active, warm, directive, medical in orientation, and willing to give advice. Clinicians, on the other hand, expect to be nondirective and "neutral," and they require their patients to be introspective and verbally active. The dropout rates of up to 60% after the first interview have been attributed to these discrepancies. As a result of these findings, many clinicians and investigators have expressed doubts as to whether or not patients of the lower social classes could be treated by long-term psychotherapy. These clinical practices emerged from an era in which long-term psychotherapy was virtually the only outpatient psychiatric treatment that had any respectability in this country and was considered by many to be the very essence of American psychiatry. Unfortunately, the applicant’s need for treatment often became less important than his credentials for "suitability.”

Two important developments in psychiatry are changing these practices. The first is the advances in technology (ie, psychopharmacology, behavior therapy and structured learning therapy, family therapy, and brief therapy) that better enable the clinician to respond to a broad variety of patient complaints, requests, and needs. The second development is the financing and delivery of psychiatric services through community mental health centers and health maintenance organizations. These changes have resulted in greater accessibility to treatment for a broader range of patients, a commitment to treat all patients from a catchment area, a broader definition of psychiatric problems, and a new power relationship between patients and clinicians.

This change in the physician-patient (professional-client) relationship, described by sociologists interested in health, is already upon us. Indeed, it seems probable that the patient will increasingly view himself as a purchaser of services, a “well paying customer in a buyer’s market.”

Some professionals find the word “customer” crass. We believe it is a useful metaphor to describe a relationship in which the patient has the right to ask for what he wants, to negotiate, and to take his business elsewhere if he so desires, while the clinician has the obligation to listen, negotiate, and offer treatment that meets his professional standards. This “customer” relationship, we believe, is in the interest of both parties. On the other hand, a relationship characterized either by the patient taking whatever he wants or can pay for (as in a supermarket), or by the clinician doing what he wants regardless of the patient’s wishes, runs the risk of being ineffective or even destructive to both parties.

As mental health professionals enter into clinical situations arising from the technical advances and social changes described above, new clinical demands will be made of them. They will become frustrated and fatigued. We believe that this discomfort results not only from limitations in the diagnostic system and clinical formulations but from our approach to patients. In this report we have attempted to conceptualize for the mental health professional an approach to patienthood based on the mutual influence between clinician and patient. We believe this approach results in improved patient care, patient satisfaction, and staff morale.

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References