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The evolution of the Nurse-Patient terminology

Dimitrios Theofanidis

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EDITORIAL ARTICLE

THE EVOLUTION OF THE NURSE-PATIENT TERMINOLOGY

The terminology used in the nurse-patient relationship has evolved notably, especially over the past decades, reflecting a marked shift from the dictating stance of the strict hierarchical nurse to patient stance to a more collaborative and patient-cantered approach. Hence, the patient per se has been evolving from a passive to an active role, i.e. from a simple and often obeying recipient of healthcare to an equal participant in their health decision-making.

Yet, before examining the complex context of the nurse-patient relationship, it is important to first consider the labels used to describe the terms commonly used such as 'patients', 'healthcare recipients', 'clients', 'customers', 'healthcare consumers', 'service users' and 'experts by living experience'. A detailed description of the definition of the terms and a relative criticism can be found below.

Patients: A universal definition of a patient is an individual in need who seeks out the assistance of a healthcare professional. The word 'patient' originates from the Latin word 'patiens', which means 'suffering' or 'enduring'. Conversely, paciente, implies capable of enduring misfortune, suffering, etc., without complaint. The term 'pacient', deriving from the Old French, reflects bearing, supporting, suffering, enduring, permitting. From the late 14c. it also depicts slow to anger, self-restrained, having the temper which endures trials and provocations. Finally, from late 15c. it is associated with: 'awaiting or expecting an outcome calmly and without discontent'. Yet, 'patient' in modern Greek is translated as: 'άρρωστος' or 'ασθενής'. These words are derived from ancient Greek whereby 'α' denotes 'lack of', i.e. without 'ρώμη' - actual strength or without 'σθένος', i.e. mental or physical strength. The actual translation may reveal a deeper underpinning philosophical stance towards health or cultural conventions of illness and recovery. In this light, the patient's voice should be heard in order to shape services accordingly. Yet, studies show that often patients have trouble in locating doctors easily and complain about staff being impolite and somehow careless.[1]

Still, a modern patient-oriented health care service should be focusing on the patient as a health care user rather than a 'patient' per se. Hence, various socio-political forces, such as a gradual shift from a paternalistic to a patient-centred model of healthcare, have prompted a long-standing debate about the use of alternative labels to describe 'patients'. Whereas the term 'patient' may summon an image of a passive individual awaiting treatment, terms such as 'client', 'consumer', 'customer' and 'service user' have been proposed in order to reflect a more empowering status, with greater equality between participants in personal healthcare decision-making.[2]

Clients: The term 'client' was introduced during the early '80s mainly by social workers in the UK who started reviewing their 'patients' not as 'almoner recipients' anymore, highlighting also the difficulties in establishing a role for nurses in relation to the health sector within the then new welfare state. Yet, the term 'client', however, became more acceptable and is still the most widely used term internationally to describe the nurse-patient relationship.

In the UK, however, the term 'client' came to be challenged both from within and outside the profession as there has been growing concern that a 'client' represented an objectification of the nursing work relationship whereby it was assumed

power on the nurses' part who were put in a position to identify what 'the passive client' needed.

Hence, under this context, a 'good' client was one who accepted the professionalism of the nurse to assess their needs and willingly acted on what they were asked to do.

Customers: The reconstruction of clients from citizens with rights to customers of market-produced services represented the invocation of a new identity. This alternative identity challenged how we thought about people who buy/consume healthcare services.[3] Hence, 'consumer' assumes that the ideally the patients are able to rationally access services through the market, 'buying' in services in an effective and efficient way to meet their own needs, irrespective of whether the healthcare provider is state or private service.

There is also an inherent assumption of rationality that is challengeable here, i.e. it is assumed that the 'patients' are capable always to make a rational and informed choice in full awareness of the relevant facts and features of their healthcare status and after a scrutinized analysis of the potential consequences of each of their choices, they are able to select the one which is most likely to serve their best interests.[4]

Such a view negates how social or personal circumstances impact on individuals' abilities to make rational decisions and, as the examples of smoking and alcohol misuse clearly indicate, people are able to make choices which will ultimately harm themselves. Hence, critics have been arguing that the term 'customer' signifies the extreme marketization of healthcare. Hence, patients being 'costumers' signify a relationship in which healthcare is seen as a product, created by the healthcare multi-complex industry and managed by a case manager who is accountable to their managers much more so than to their profession or those using the service. Overall, under his light, healthcare is widely viewed as a commodity for the consumer and their free will to 'shop' for services. Consequently, the healthcare worker becomes more of a broker, accountable to management, or even an entrepreneur in the case of private residential homes.

Healthcare consumers: Thus, whilst the rhetoric of service user involvement may be very positive, there remain questions as to its nature, impact and benefits. This is not to say that the author does not believe that meaningful service user involvement is intrinsically beneficial to social work and social care, but that we need to adopt a critical stance towards it to ensure service user involvement remains honest and does not degenerate into a tick-box exercise. This now leads onto a critical exploration of the term 'service user'.

This section begins with a critique of 'service users' as a descriptive term for homogenous populations and then moves on to a more specific critique of its current use whilst also highlighting the issue of those who are eligible but do not receive services they want. In social care, social workers may refer to 'service users' in order to define a group of people with mental health needs, those who attend a children's centre or those accessing respite care. In terms of recruiting service users for management consultations, evaluation exercises or research studies, it is often claimed that it is impossible to be representative of all services. It is also said that managers, evaluators and researchers only chose the 'usual suspects' and unrepresentative service users. Prostle & and Beresford (2007) robustly point out, in relation to service user movements, that the issue is not one of representativeness, but one of inclusion. It is just as limiting to think that all managers, social workers, nurses or researchers think all the same as it is to suggest that there is just one service user voice.[5]

Service users: A 'healthcare service user' is anyone who accesses or is eligible to access healthcare services. Hence, this term is used to describe individuals who utilize these services and, in this respect, service user involvement is crucial in healthcare development, education, and research. The notion of 'service user' stems from a consumerist version of the 'service user as king'. The term originated most likely from non-statutory services like the food or hotel industries and it is the preferred term when consulted by mental health nurses as it reflects the 'client is always right' motto. The drive for a 'service user' mandate stemmed from both the consumerist tradition of the 1990s and the democratic tradition of developing participation to ensure the suitability of services.

Yet, critics argue that the term is overstating, as service user involvement is all too often tokenistic and unproductive. There are also arguments that service users' knowledge is being appropriated in areas like anti-oppressive practice, reinforcing oppression and the view of service users as passive whilst protecting professional power and legitimating controlling problematic practices. The 'service user' movement challenges this view with a demand for a voice and an increasing say in how services are developed and delivered, especially as they are the ones whom the services were expected to support and help.[6,7,8,9]

Another criticism for the term 'service user' entails that it was more likely to be interpreted in terms of successful processes as opposed to successful outcomes. Hence, it is claimed that involving service users has become more important rather than providing more effective services per se.[10]

Healthcare recipients: This definition also answers some of the earlier criticisms of the use of 'service user', with its wider awareness of those who are refused services and those who are living with or caring for a service user. However, it is not without its own difficulties, as it includes an assumption that those who needed services and were not provided them and those who received an inappropriate decision have made an accurate assessment of their own situation. To put it another way, it assumes those who undertook the assessment were wrong. Whilst it is certainly possible that the social worker or social care worker may have made an inaccurate assessment, it is another thing to suggest that this is the accepted reason why people do not receive the service they want or that the services they receive are inadequate for their purpose. Within this definition, there is an assumption linked to the consumerist perspective whereby the 'customer is king' and hence always right. Surely, it is just as indefensible to assume that professionals are always wrong as it is to assume service users are always, right? As already noted, would society be prepared to sanction those who perpetrate child abuse to say they did not require social work help or for those with a chronic mental illness to decide they did not require treatment?

Experts by living experience: 'Experts by experience' is a newly introduced reclassification of the classical nurse– 'patient' relationship, as it, unlike 'service user', 'client', 'consumer' or 'customer' before it, makes a claim for a specialist knowledge base rooted in an individual's experience of using the healthcare services. The nurse working with the 'expert by lived experience' suggests a new relationship of equals whereby one expertise has been accrued through training and practice and the other through their lived experience.

This suggests that the nurse needs to acknowledge and affirm the expertise of the 'patient' in assessing and agreeing a way forward. 'Experts by experience' has been increasingly favoured as a movement to draw attention to the value of

working alongside service users by acknowledging a person's capacity to work towards their own rehabilitation and cure.

Yet, even the term 'experts by experience' has been viewed as problematic when the limits of 'expertise' are examined and a series of relevant questions need to be addressed, such as:

- Who is, and is not, an 'expert by experience'?
- Who decides, and what criteria is used?

Hence, the lay use of the term 'experts by experience' raises a debate on the actual term which encompasses both 'expert' and 'experience', hence ignoring those individuals who do not learn constructively from experience.

CONCLUSIONS

This critical discussion paper has examined the ways we use to describe the relationship between those who provide services and those who receive them. In particular, we have critically considered the terms 'client', 'consumer', 'customer', 'service user' and 'expert by experience' and found all these terms are still challenging as a modern people-oriented health care service should be focusing on the patient as the focus of care both in terms of optimum outcomes but high-quality processes as well.

In particular, each of these terms reflects a power struggle describing the relationship slightly differently, the use of 'Client' (emphasizing passivity), and the use of 'Customer' or 'Consumer' (indicating a managerialization and/or marketization of the nursing input, implying that the customer or consumer wishes are paramount), 'Service user' (whilst being an improvement on previous conceptions, is still seen to be flawed) and 'Experts by experience' (which acknowledges that users of healthcare services bring their unique expertise and lived experience to the relationship).

However, healthcare professionals need to consider whether it really matters which label we use as whichever discourse we decide to adopt indicates a power dimension and hierarchy of control over people lives.

It is widely recognised that whichever term we choose to use (i.e. 'patient', 'client', 'service user', 'consumer', 'customer', or 'expert by experience') it is descriptive not of the person (patient) per se, but of the professional relationship framework within which we interact with that person.

Hence, it is not 'simple terminology', but rather the language we use does label individuals in different ways, hence, it acts as both a signifier and can even be an external social control.

If nursing is concerned with patient empowerment, being a patient's advocate through the complex healthcare 'industry', it becomes essential to develop a continuous critical dialogue concerning the language we use, deconstructing it and unearthing the assumptions behind its usage.[11]

Suggestions of a new term to replace the 'outdated; term 'patient' include 'people', 'active consumers', 'responsible consumers' or even 'citizens', but all these contain their own assumptive worlds and fail to effectively and accurately reflect the nature of the nurse-patient relationship. There have even been suggestions to allow those who use healthcare services to decide how they wish to be addressed and described instead of actively looking for one alternative new word for this relationship.[12]

Overall, we need to remember that whatever term we choose to adopt, or even if we devise a new one, we should critically reflect on how we constructed it and consider whether there are not any more accurate and better ways of doing this by reflecting on the full spectrum of the inherent nature and challenges of nursing work per se.

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Dimitrios Theofanidis
Assistant Professor, School of Health, Nursing Department
International Hellenic University