that judges can "agree in rating psychoanalytical aspects of interpersonal relatedness, and that such judgements have clinical relevance".

Quality of object relations is defined as a person's enduring tendency to establish certain types of relationships that range along an overall dimension from primitive to mature. In a semi-structured interview, the patient's life-long pattern of relationships is explored in reference to criteria that characterise five levels of object relations. An overlap with Hobson *et al*'s interview and Personal Relatedness Profile (PRP) is suggested. Of the 30 items from the PRP, we judge 22 to have clear parallels with the QOR criteria.

Hobson *et al* report satisfactory reliabilities for most items of the PRP. The QOR scale has been refined through its use in five clinical trial studies of time-limited dynamic therapy, with progressive improvements in inter-judge reliability. In a current comparative trial of short-term group therapy, two reliability studies have each returned intraclass correlation (ICC(2,2)) values of 0.81.

Hobson *et al* also report that the PRP successfully discriminated between patient groups defined by diagnoses of borderline personality and dysthymic disorder. In our work, we have examined subgroups defined by low and high QOR scores. Low-QOR patients tend to show more pathology on pre-therapy measures of outcome, notably those indices addressing interpersonal functioning. Quality of object relations has been found to be a direct predictor of the therapeutic alliance (Piper *et al*, 1991) and outcome in brief individual therapy (Piper *et al*, 1998), and of remaining and benefiting in a day treatment programme (Piper *et al*, 1996). Quality of object relations also appears to be a moderator of the impact of transference-focused technique in brief individual therapy. In short, QOR has provided important indications regarding the selection of patients for psychodynamic therapy and for the use of particular techniques with particular patients.

We encourage Hobson *et al* and others to continue the development of theoretically relevant measures of psychoanalytic constructs and examination of their clinical utility.

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'Patient *v.* client'

Sir: A patient is someone I attend to, treat and work with. Webster's (1987) *Dictionary* defines patient as "One that suffers, endures or is victimized". The word is derived from the Latin *pati* (to suffer). It saddens me to see some colleagues referring to patients as 'clients'. Webster's defines client as "A person who engages the professional advice or services of another". It is derived from the Latin *clinare* (to lean). Prostitutes and lawyers may have clients. Psychiatrists have patients.

Clinical social workers prefer to use 'client' (Lieberman, 1987), as do psychologists. Occupational therapists lean towards the use of 'client' and psychiatric nurses use both. Social workers brought 'client' from the field of social welfare, where its use attempted to avoid imposing a sick role. Its use in the field of psychotherapy was geared towards avoiding the medical model. Its use by nurses and occupational therapists seems curious. It is inaccurate to claim that a 'client' *engages* their professional services.

Words have meanings and significance. The use of 'client' reflects an assumed equality in the relationship. However, the inherent inequality between psychiatrists and patients is recognised in the ethical and legislative restrictions placed on relationships between psychiatrist and patient. Sharrott & Yerxa (1985) quoted Pellegrino, "There is . . . a special dimension of anguish in illness. That is why healing cannot be classified as a commodity, or a service on a par with going to a mechanic . . . to a lawyer . . .".

Use of 'client' to describe a patient ignores the ethical and moral bond between psychiatrist and patient, one which is based on non-maleficence and beneficence while still respecting patient autonomy.

I urge all mental health professionals to abandon the cold, inappropriate 'client' to describe the individuals who entrust us with their care.

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Schizophrenia and diabetes mellitus

Sir: It is reported that patients treated with clozapine are more often classified as having type 2 diabetes mellitus or impaired glucose tolerance compared with patients in a control group (Hagg *et al*, 1998). Clozapine increases the risk of diabetes if there is a history of pre-existing diabetes, a family history of diabetes or if the patient is Black. Such patients may need close blood sugar monitoring during initiation of clozapine treatment (Popli *et al*, 1997).

We report the case of a 30-year-old Black male, diagnosed with schizophrenia 10 years ago. He has no history of pre-existing diabetes or a family history of diabetes. He was detained in a medium secure unit. Resistant to traditional depot antipsychotic medication, he was commenced on clozapine. The dose was gradually increased to 325 mg daily. After three months, he developed a sore throat, felt lethargic and unwell. His speech became slurred and he was thirsty. Blood sugar was 19 mmol/l. Clozapine was stopped and he was admitted to casualty in a hyperglycaemic ketoacidotic state. He made a good recovery and his diabetes resolved completely. Clozapine was discontinued.