USER, CLIENT OR PATIENT? WHICH TERM IS MORE FREQUENTLY USED BY NURSING STUDENTS?[1]

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ABSTRACT: The present study aimed to identify which term is more frequently used by nursing students - user, client or patient – and also to acknowledge the collective understanding of each term. This prospective, quantitative-qualitative research was conducted at the Nursing School of the University of São Paulo with students from all Nursing Baccalaureate years. From the 215 students approached by the study, 162 responded to the question. Of this number, 60% used the term user most frequently. Regardless the term employed in healthcare practice, it is important to highlight that the common concepts of autonomy and health service must be respected as a right, while the inhumane relationship and passiveness must be ousted in the dialogic relationship established between healthcare professionals and users-clients-patients.

DESCRIPTORS: Nursing. Bioethics. Education, nursing. Students, nursing.

USUÁRIO, CLIENTE OU PACIENTE? QUAL O TERMO MAIS UTILIZADO PELOS ESTUDANTES DE ENFERMAGEM?

RESUMO: Este estudo objetivou identificar qual o termo mais utilizado pelos estudantes de enfermagem, usuário, cliente ou paciente, e também conhecer a compreensão do coletivo sobre cada termo. Estudo prospectivo, de corte quanti-qualitativo, realizado na Escola de Enfermagem da Universidade de São Paulo, com os estudantes dos quatro anos do curso de Bacharel em Enfermagem. Foram abordados 215 alunos, dos quais 162 responderam e, destes, 60% utilizaram o termo usuário. Indiferentemente do termo a ser empregado na prática do cuidado, é importante ressaltar que os conceitos comuns de respeito à autonomia e serviço de saúde como um direito devem ser respeitados, da mesma forma que a relação desumana e a passividade devem ser deixadas de fora na relação dialógica que se pretende estabelecer entre os profissionais de saúde e o usuário-cliente-paciente.

DESCRITORES: Enfermagem. Bioética. Educação em enfermagem. Estudantes de enfermagem.

¿USUARIO, CLIENTE O PACIENTE: A QUIÉN SE CUIDA COMO ESTUDIANTE DE ENFERMERÍA?

RESUMEN: Este estudio tuvo como objetivo identificar el término más utilizado por los estudiantes de enfermería: usuario, cliente o paciente, y también saber acerca de la comprensión colectiva de cada término. Estudio prospectivo, cuanti-cualitativo, celebrado en la Escuela de Enfermería, Universidad de São Paulo, con los estudiantes de los cuatro años del curso de Licenciatura en Enfermería. En total 215 estudiantes fueron abordados, 162 respondieron y de estos 60% utilizaran el término usuario. Independiente de cual término es empleado en la práctica de la atención es importante señalar que los conceptos comunes de autonomía y atención de salud como un derecho deben ser respetados, de la misma manera que la relación inhumana y la pasividad deben ser dejados de fuera en la relación dialógica que debe establecerse entre los profesionales y el usuario-cliente-paciente.

DESCRIPTORES: Enfermería. Bioética. Educación en enfermería. Estudiantes de enfermería.

INTRODUCTION

User, client or patient? People who access healthcare services are usually referred to by one of these three terms. Each term has a unique meaning and should not be considered on a semantic basis only. The terminologies promote and induce distinct ways of looking at and comprehending named objects, or the way we build reality.[1]

The professional relationship conotes the idea that the patient is a client above all; that is, a user or a service buyer, regardless of the context in which he is assisted.[1] Therefore, there is no consensus regarding the terms client, patient and user in terms of the relationship between the person who makes use of healthcare services and the healthcare professional.

Therefore, we need to be cautious and mindful whenever we employ these expressions. It is necessary to pinpoint some differences, as the three terms are grounded on various roots, in spite of being used synonymously. The term "patient" began to be used in the 14th century and referred to a patient (as opposed to impatient), serene, resigned person.[2]

Most professionals consider the lack of emotional involvement with patients to be a way of taking care of themselves, protecting themselves from becoming too emotionally involved: the closer the relationship between patient and nurse, the more likely it will be for the professional to share his feelings with the patient.[3] Besides suggesting a more intimate relationship, the term "patient" is actually the most universally used terminology.

However, the use of this term may implicitly suggest a passive and hierarchically lower position in relation to the professional, as the origin of the term is from the word "sufferer", derived from the Latin word "patiens", from "patior", meaning "to suffer".[4]

The term "client" originated from the vocabulary of the market's liberal economy.[1] It stands for healthcare's "liberal exercise" and/or private healthcare, assuming both that the person that seeks healthcare services is, in a certain way, a consumer, and that healthcare is a consumption good, instead of a social right.[5]

A user is anyone who uses or enjoys a collective good related to a public or private service.[6] Therefore, the term "user" seems to be a broader term capable of extending beyond passive and liberal concepts to a place where health is not only perceived as a consumption good regulated by market laws, but also a turning point where the concept of healthcare is perceived as a human and social right regulated by citizenship.

It is obvious that the employment of any of these terms does not eliminate the use of the others. A mix of the three terms can be observed frequently in healthcare services, and professionals are mostly unaware of their representations, or how they complement or oppose each other.[7-8]

However, in healthcare practice, the relationship established with people who seek these services must be problematized in a contextualized way, so that the produced knowledge may be used with justice and care with an eye towards social welfare. Bioethics implies a conjoint, deliberate construction of practical knowledge. It allows for a broader understanding of reality by means of a mutually built confrontation between facts and values involved in the user-client-patient correlation.[9]

The understanding of the use of these terms may become a powerful tool aimed at producing deep reflection regarding healthcare practice, especially when such a reflexive action is initiated in the undergraduate period, as students will be the professionals who make use of these terms in their practical field in the future.

Hence, due to the synonymous use of these three terms, this study posed the following question: which term is more frequently used by nursing students and what is the collective understanding of students regarding these terms? In order to answer these questions, this present research aimed to identify which term is more commonly used by nursing students enrolled in the School of Nursing of the University of São Paulo (EEUSP) and also acknowledges the understanding of these students regarding the use of the terms "user", "client" and "patient".

METHODOLOGY

This prospective, quantitative-qualitative research was conducted at the School of Nursing of the University of São Paulo with students from all Nursing Baccalaureate years.

Data collection occurred inside and outside the classroom. At first, students were informed about the research and those who agreed to take part in the study signed the Free and Informed Consent Form. Following, each student received an envelope with the following question: "Who do you care for in your practice as a nursing student?" From three identical paper slips placed in the en-

velope, which read "user", "client" and "patient", the student chose the most adequate response in his opinion. The interviewee was then asked to justify the reason for his response on the back of the appointed paper.

Due to time and location conflicts, we were assisted by important supporters previously instructed regarding the objectives of the research in approaching students, handing out the envelopes and collecting data.

The envelopes were handed back to the researchers together with the consent forms. Completed papers were picked up, identified and registered using an analysis software for qualitative and quantitative data called Qualiquantisoft®. In the identification process, the first recorded number represents the undergraduate year (1, 2, 3 or 4); the following numbers capture the sequence of received responses: for instance, a second-year student and fourteenth respondent received identification number 214.

After analyzing the frequency and the average participation of students, we employed the Discourse of the Collective Subject (DCS)[10] tool, aiming at building a concept for each term (user, client and patient) based on the collective vision of the students.

The DCS is a technique used to organize discoursive data in qualitative research and allows for the rescuing of the whole stock of known representations on a given issue, in a given universe. The thoughts of a certain group of subjects on a certain matter, expressed in a discoursive way, is the raw material that is managed by the DCS. The discourses are submitted to content analysis triggered by breaking them down to major anchorings or core ideas present in each individual discourse, and also in all of them together, followed by a synthesis aimed at reconstructing the social representation of the discourse.[10]

The steps in the synthesis in the DSC include: 1) repeated readings of the set of statements collected from the interviews; 2) readings of the answer to each particular question and highlighting of selected key expressions; 3) identification of core ideas for each answer; 4) analysis of all key expressions and core ideas and gathering of similar statements into homogeneous groups; 5) identification and naming of the core idea in the homogeneous group, which will become the synthesis of core ideas in each discourse; 6) construction of a specific DCS in each group formed in the previous phase; and 7) assignment of a name or identification for each DCS.[10]

A key expression is a literal transcription of continuous or discontinuous excerpts or segments of the discourse, enabling the rescue of the essence of the discoursive content. This is a crucial moment in the analysis, as the comparison of selected key expressions with the full discourse, and also with core ideas and anchorings, allows the reader to judge the pertinence of the interpretation of the statement made by the researcher, which conveys to the key expressions a sort of "discoursive-empirical evidence" concerning the veracity of the performed content analysis.[10]

A core idea is a name or linguistic expression that translates the essence of the discourse content uttered by the subjects. It reveals and describes the sense and the theme of each analyzed statement, thus constituting the synthesis of a given discourse or a group of homogeneous discourses.[10]

In this way, if one wants to build a DCS, it will be necessary "to discourse", or in other words, ordain key expressions under a sequence, in such a way that the discourses have a beginning, middle and end, or are driven from the general toward the specific. The connections observed among the parts of the discourses or paragraphs are achieved by the introduction of connecting words, such as "soon, thus, then, finally", among others. The repetition of ideas must be avoided, except when they depict distinct ideas, expressions or words, even though they may seem to be similar. Peculiar expressions regarding sex, age, events or specific diseases must be eliminated by a process called "de-particularization".[10]

This research was approved by both the School of Nursing Board and the Committee on the Ethics of Human Beings Research (CER/EEUSP) under protocol number 123/2010/CPq/EEUSP. The students were instructed about the research and their anonimity and freedom of engagement in the study were ensured. The study also respected the ethical precepts prescribed by Resolution CNS 196/96 of the Ministry of Health.

RESULTS

Data collection was conducted in the second half of 2010, when 215 undergraduate students from the school of Nursing were approached. There was a difference between the number of approaches and the number of feedbacks received in each academic year. Among the 60 first-year students approached, 47 agreed to be interviewed; among the 65 second-year students approached,

58 agreed; among the 45 third-year students approached, 40 agreed; and among the 30 fourth-year students approached, 17 agreed to participate in the interview.

As for the question posed by the research, different terms were favored by the students from each undergraduate year, as can be seen in table 1.

Table 1 – Quantitative distribution of terms used by EEUSP students according to undergraduate year

Year	1st	2nd	3rd	4th	Total
Patient	15	16	10	5	46 (28%)
Client	2	10	6	2	20 (12%)
User	30	32	24	10	96 (60%)
Total	47	58	40	17	162 (100%)

Based on the data organized by the Quali-quantisoft® software for each presented term it was possible to identify five core ideas related to the term "patient", four related to the term "client" and five related to the term "user". These ideas and their equivalent collective discourses were divided by terms, as presented below.

Patient

Patience while waiting for care

Patient is the person who waits, that is, someone who must have patience and wait for healthcare professionals to act and intervene. Sometimes, the waiting time is so long that the patient thinks for goodness sake, it's taking forever! It does demand patience.

Ill person that needs care

Patient is the person who needs special care and support in the short, mid or long term. It is someone that is hospitalized, frail and in need of individualized care, as each person becomes ill for different reasons, facing their conditions in quite a unique way.

Humanization, bond and respect in the care process

Patient generates a concept of intimacy and respectfulness. It clearly exemplifies a certain degree of bonding and respect, thus humanizing the relationship and breaking the association with the institution;

in other words, it reveals a close interaction and not a service- rendering process.

Traditional denomination

The word patient is the oldest and most common conventional denomination. It's the term that most reminds us of the context of a hospital. It's the terminology used in the undergraduate period and also during the nursing internship. Thus, we appropriate the term after hearing it repeatedly.

A passive person during the treatment process

Patient characterizes the individual as a passive being in all healthcare practices. He just can't voice his own opinion. It reminds me of someone who only receives orders and instructions; that is, someone who is not very active regarding his own health care and recovery. It reminds me of the past, when people were totally dependent. It removes from the assisted person his right to act, to express his will. The person seems obliged to accept what is imposed, without any critical reasoning, or any resistence. Hence, the term suggests a person with no attitude whatsoever, no thought, no belief, someone who has become a mere object in the professional's work.

Client

Up-to-date

Client is the current denotation, the most modern word to identify a person that makes use of healthcare services.

You always pay for health

Client is that person who makes use of a service or a product he paid for. Regardless of the public or private source of the service, citizens pay for healthcare services in the form of either insurance or a tax.

Positive commercialization of health

The nursing occupation represents a relationship between a service renderer and a client; therefore, it is understood that the client pays for the service rendered. The client is a buyer, even when (the service) is not directly remunerated. The client is the one who keeps the service renderer vs. consumer framework of this service. All sorts of care can be understood as an exchange of values and costs, where the autonomy (of the client) must be sustained, as well as his rights and

duties. He must participate in the construction and improvement of the service, he has to express his opinion, complain and make suggestions; in addition, his ideas and thoughts must be taken into account in care quality assessment programs. The term client forces us to treat people more efficiently, because health care must be directed to those we care for. We have to be patient and render a humanized care, because every one has the right to receive quality care. The health professional has the duty to offer comprehensive care to people.

Negative commercialization of health

Client seems to be more related to a comercial product, to exchange relationships only, leaving sentiments out of the equation. It's a cold term that removes the humanization of the care, the human-based exchange that takes places during practice. It belittles health care and turns it into a commodity. It conveys the impression of an individual who privately pays for health care, where the hospital stands out as the supplier and the client as the buyer of the service. It forwards the issue to the field of profits; that is, it becomes a privatized term directed only to commercial interests, as if care can be sold. Even though it suggests autonomy, the term generally points to a person that will receive care if he can afford it; and when he can, it seems to point out that that person has to be assisted in whatever ways he may demand.

User

Comprehensive care

User not only points to the biological aspects of care, but also to the psychosocial care. It encompasses the individual in all his dimensions, in his time of being ill or healthy, regardless of the presence or absence of a disease. It includes the family and potential strengths and weaknesses. It also entails the person who receives either curative or preventive treatment, or healthcare promotion/education.

Integrates client and patient

User is the most adequate term for the person who makes use of healthcare services. The user is the patient and the client at the same time.

Exclusion of passiveness and commercial healthcare ideas, thus not demeaning the ill person

User does not denote a passive type of care, or a submissive position as is suggested by the term patient,

or even a strictly commercial, capitalistic relationship that turns healthcare into a commodity as with the term client. None of the meanings of the word user demeans the ill person. As the term addresses the idea that the person who seeks healthcare services has autonomy over his own health, having the power of choice, his decisions and will must be taken into account. The person may and must question methods and reasons for the treatments he is subjected to and can decide the manner in which his care/treatment will occur.

Health care as a citizenship right

User shows the right the whole population has to enjoy healthcare services in a more egalitarian way. The healthcare service is a right of all human beings and a duty of the State. Citizens must feel free to fully use it, whenever necessary. A user is someone who uses the resources the public or private healthcare service has to offer, both in the hospital and in a primary healthcare unit. Therefore, the term addresses all individuals, regardless of whether they can or can't afford the services. After all, in any care level, the person is making use of a service.

Drug user

User reminds me of those people who use drugs and other substances.

DISCUSSION

After organizing the data, it was possible to discuss the differences in the participation of the students in the research, as well as the elements of the Discourse of the Collective Subject (DCS), based on the reflection promoted by the Deliberative Bioethics.

The fact that more first-year students took part in the research in comparison with fourth-year students may be related to the different experiences and expectations of these groups.[11-12] In the first year, students are beginning to discover the academic world, and are still strongly stimulated by their achievement on the entrance examination (Vestibular) and by their newly acquired freedom. Towards the end of the course, however, the student tends to be overloaded and exhausted by their final assignments and focused on their insertion in the job market.

The justifications presented by the students for the use of each term highlights implications referring to the ideological environment of this group.[10] Lefèvre states that the "collective

imaginary can be considered as an ideological environment that, exactly as the physical environment, necessarily and diffusely affects all individuals".[10:32] Hence, it is important to recognize the complexity involving the use of each term in order to better understand each choice.

The relationship of the term "patient" to "patience to wait for care" reflects upon the thoughts existing in the collective imaginary in the healthcare service area, as both the public and the private services show disrespect for appointment, exam, surgery and visit times, to name a few. Existing researches that examine ethics, bioethics[13], rights and duties[14] show how difficult it is for citizens to be empowered; they also show the great lack of personal and public stimulus toward changing a reality that does not favor the development of citizenship in healthcare services.

In harmony with this perception, whenever the term "patient" is used as a traditional denomination for an ill person requiring care who is a passive subject in the treatment process, the students also demonstrate how critical thought is developed in educational environments. Distinct authors[15-16] stand by the idea that a reductionist paradigm in the health-disease process compromises the development of a problematizing and dialogic teaching process. Hence, discussions about the comprehensiveness and the broad vision of care[16] can help build up critical thinking skills in nursing students, causing them, in this case, to rethink this rationale.

In any case, when students relate the term to concepts of humanization, bonding and respect in the care process, it can clearly be seen that the precepts set by the Unified Health System (SUS) have been moving into the academic environment, thus fulfilling the goals set at the time the *HumanizaSUS*: National Humanization Policy[17] was published.

The term "client" was also justified by the students as being a word that addresses the present time. The term has just recently been applied in the healthcare system. Its use still provokes confusion at times, but it was interesting to identify that the awareness that one always pays for a healthcare service is very consolidated in the students' imaginary. After all, it is essential to characterize the SUS not as a free service, but as a service to be used by the population, thus demanding a strong financial commitment on the part of the public .[18]

This term also highlighted the duality of the commercialization of health care. As a positive aspect, it is worth emphasizing a stronger degree of commitment to care, both on the part of the professional and on the part of the client.[18-19] However, the mere replacement of terms does not necessarily mean a change in behavior. Moreover, one must be careful in order not to adopt the negative concept of the term "client", as it can be turned into a "simple individual consumer of services provided by the State".[20:6]

Other authors make use of both terms (client and patient) in their studies, establishing[19] [21-22] some differentiation, while others justify their decision for not using the term "client" due to its historical origin related to vassal-like concepts, or the idea of being someone's protegee.[18,23]

The onset of the use of the term "client" shows a close connection with the theory of quality in services. In manufacturing sectors, the expression is associated with innovation of the managerial theory, especially when the administrative practice begins to redefine the way people are treated, altering them from the condition of being mere human "resources" and levering them to a place where they are seen as nuclear and complex necessities of organizations.[24]

Most of the students (60%) chose the term "user" and justified their choice in the capacity the term has to integrate the other concepts (client and patient), aiming at excluding the idea of passiveness and of health as a commodity, in order not to demean the ill person.

This choice corroborates the current dynamics of healthcare policies and healthcare education,[25] leading the citizen to a position of autonomy and empowerment; at the same time, it also stimulates the critical and reflexive thinking of professionals in favor of the discussions promoted by the bioethics area.[26] In this way, this understanding allows for the comprehensive care of the individual who is seeking healthcare services grounded on a commitment to the precepts of universality defended by the SUS, as well as the understanding of healthcare services being a matter of right and citizenship.

Healthcare comprehensiveness can be understood from "three inter-related ideals: to see the patient as a whole and not only as a carrier of a specific disease; to integrate preventive and curative actions; and to integrate all healthcare operational levels (primary, secondary and tertiary)"[18:1]. Only a responsible commitment toward care can generate respect and promote autonomy, citizenship and health for everyone.[26]

Popular participation and social control, one of the pilars of the SUS, grant the user's autonomy a two-fold dimension. The clinical dimension refers to his capacity to make decisions regarding situations that affect his life, health and well-being. The political dimension implies his participation in decisions related to healthcare policies and service organization.

Hence, the universality of the healthcare system presupposes the engagement of all citizens in political-administrative decisions in the healthcare sector. This fact causes us to recognize that in the political sphere, professionals must act like advisors and politicians must act as managers, leaving decision-making processes to the users.[27]

The term "drug user" expresses the understanding of how the previous dissemination of the negative context of this term in our society still influences the discourse of these collective subjects. At the same time, it also awakens inquiries in regards to the way these students have been encouraged to question traditional ideas in our society.

In the same way, one can question whether or not the mere change in the use of the term to designate who is cared for by healthcare services actually generates a true transformation in the care relationship observed between a nursing student and the client-patient-user.

Therefore, as young people, students should be awakened to their natural creativity through the stimulus of their original ideas and the knowledge that the identification of knowledge gaps in certain areas can point out investigation needs and priorities.[28]

The relationship between professors and students should be less authoritative and verticalized in order to promote a more horizontal relationship between professionals and clients-patients-users, thus configuring a binomial participation-collaboration.[29]

Bioethics contribute to the transformation of such a posture, as they shows that our daily relationships are surrounded by and consist of transitory truths. Thus, besides the acquisition of skills and knowledge, students have to learn how to act in a humble, tolerant and respecful way toward the moral pluralism of society, aiming at building clinical relationships grounded on shared responsibility and a deliberative environment.

Health professionals in general, and nurses in particular, have to leave contentious and/or neutral attitudes aside and access the world of deliberative behavior. Deliberative behavior is tolerant, but does not take a neutral position. It understands that there are values that deserve to be defended and carried out in the healthcare area, while others should be avoided. The acceptance or rejection of such values must be critically justified.[29]

Care practices occur in the real day-to-day world, as complex, shared and constant constructions founded on a hermeneutic-dialetic spiral of convictions, values, facts, circumstances and consequences. In this way, the future healthcare professional must know how to (and desire to) dialogue with the other, in order to find courses of action that are neither radical nor tragic, but prudent and wise in dealing with existing problems.[9]

Whenever the actions of the professional are based on shared responsibility, he will be able to justify his practices and choices, as well as their impacts on life. He can also justify his actions later on, after connecting obligations, convictions, expectations and values. These decisions are based on circumstances, contexts and predictable consequences to his actions and options.[9]

The sense of responsibility inherent in Deliberative Bioethics is mostly regarded in its phenomenological sense. In other words, it comes close to a place of "providing answers" and "responding to": "The phenomenological senses of responsibility might be closer to a problematic of answerability than one of accountability ... responsibility first needs to be taken as a kind of response, as being assigned to a call".[31:18] In this sense, responsibility stands out as a response and is not based on a spontaneous initiative, as Kant once stated.[30]

The essential is the manifestation of reality, the revealing of things. The original experience of the human being is prior to any initiative of either the self or the subject. We usually come across things that suddenly appear in our conscience. Hence, things are imposed on us with no active intervention on our part. Thus, much more than a "position", such as is disseminated by idealism, our conscience needs to deal with "impositions". Whenever reality is revealed, it is imposed on us. Reality has "power" over us, the "power of the real", the beginning and foundation of the phenomenon named by Zubiri as "reconnection". Reality has power over us, binding and rebinding us. Whether we like it or not, we are reconnected or united to the power of the real that imposes

on us its three-fold power condition: "ultimate", "enabling" and "propelling" The power of the real creates us, enables us and propels us. Hence, the power of reality stands out as an enabling power in the "power-possibility" dialetic. It is also a propelling power in the sense that it casts us forward and compels us to live by and from the real things grounded on reality. This "reconnection molds the foundation of moral obligation, thus promoting positive powers and avoiding negative powers".[30:25]

As defended by Deliberative Bioethics, the recognition of such an obligation, as well as a reflexive, responsible process toward the construction of positive powers from the onset of the academic background of future healthcare professionals must be fostered. The outcomes of this study show that one of the pathways towards unleashing such a process is the engagement of students in research projects, either as fellows in the Institutional Programs of Scientific Initiation Scholarships or the *Ensinar com Pesquisa* (Teaching with Research) Program, or as volunteers in the meetings of Research Groups. We believe that creating research allows the opportunity to deal with reality as a source (imposition), possibility (of transformation) and motivation at the same time, something that impels us to move forward.

As the teaching-learning-reflection process is established as a cyclic and continuous process that demands an accurate perception of reality by means of a complex, comprehensive and all-inclusive health-disease phenomenon, its insertion into the research perspective in the first steps of the students' academic background enables them to build a much broader and reflexive educational profile. In this way, this practice will most likely be replicated by the future nurse, thus fomenting interdisciplinary practices in his teaching, research and care as a healthcare professional. Can the germ of this very necessary transformation lie here?

FINAL CONSIDERATIONS

"User" is the term students use most frequently. However, regardless of the employment of the term in practical care, it is important to highlight that the common concepts of respect for autonomy and healthcare service as a right must be taken into account. In the same way, inhumane relationships and passiveness must be ousted from the dialogic relationship intended to be established between healthcare professionals and users-clients-patients.

This present study contributes toward effective thought and careful reflection on what lies behind (exactly as the justifications written on the backs of the slips of paper) the imaginary of each person when he decides to adopt one of these three terms (user-client-patient) in the care relationship with the other and with himself as a healthcare individual-professional.

In conclusion, it is important to highlight the personal and academic growth awakened by this research in the life of the students-fellows-researchers who took part in this study. They are still able to use all three different terms in their care practice; however, they certainly question the reasons for their choices now.

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