Coda

Careers advice

The idea of the career patient came to me out of the blue. I was listening to a case presentation, of a kind that is dismally familiar. The patient was evidently seeing six consultants in the local hospital and a further three in tertiary centres in London. She was on over twenty different kinds of medication, including six analgesics. In the past fortnight she had attended two accident and emergency departments, and had alarmed the doctors there sufficiently for both of them to have organized urgent MRI scans of her spine. Her GP was fighting a hopeless battle to try and cut down her drugs, encourage all the doctors to communicate effectively with each other and with him, and reduce the financial impact of her behaviour on the National Health Service. As part of this battle, he had just insisted on seeing her on a weekly basis to ‘get to grips with her case’, as he put it. Needless to say, she was delighted with this proposal. It was at this point in his presentation that I found myself asking the GP why he felt compelled to disrupt this person’s highly successful career as a patient. If she was a physicist or an economist, I suggested, her level of commitment to her life’s work, and her degree of imagination and intelligence in pursuing it, might surely have earned her a Nobel prize.

I said this in jest, but it was a serious jest. I was hoping to liberate the GP from his futile mission to rescue the patient from something she clearly had no desire to be rescued from. I was also trying to debunk an unrealistic expectation that I might be able to propose something magical as an invited ‘expert’ with pretensions to knowing something about clinical supervision. In doing so, I was drawing on a well-established tradition of using paradoxical injunctions in the face of perverse systems and insoluble conundrums. 1 Yet the fact is, I genuinely thought it likely that the only feasible option here was damage limitation: not to the NHS budget, and certainly not to the patient, but just in terms of the GP’s time, frustration and exhaustion.

Career patients, it seems to me, have most or all of the following characteristics. Firstly, they have a tantalizing mixture of indisputable physical pathology on the one hand, and a vast collection of far greyer and less convincing symptoms, signs and investigative findings on the other. Almost certainly, someone will have failed to diagnose something fairly obvious like hyperthyroidism early on in their careers, and they will apologetically slip this into their narratives so that every subsequent physician will be wary of leaving even the tiniest stone unturned. Although they may have had numerous operations, both necessary and pointless, they are quite unlike Munchhausen patients, since they remain intensely loyal to their doctors, especially those who have most conspicuously failed to improve any of their symptoms. Also, their problems usually accrue slowly and in geological layers, rather than appearing as sudden and dramatic eruptions.

Next, career patients usually have a finely tuned awareness of the workings of the health service. In particular, they have an intimate knowledge of its failings, and its tendencies towards fragmentation and dysfunctional communication. This gives them an ability to provoke, intensify and make a mockery out of the inability of most hospitals or local networks to join things up. Although the mockery is done through intuition and with apparent innocence rather than by brazen calculation, it succeeds in getting doctors to carry out absurd and improbable interventions (like two MRI scans in a fortnight) in preference to picking up the phone and talking to each other.

There is a very large literature on various kinds of patients who in some ways overlap with career patients: frequent consulters, heavy service users, somatizers, ‘fat file’ patients, heartsink patients and so forth. Much of this literature purports to offer advice about how to work more productively with such people. Suggested tactics include: psychosocial inquiry, reattribution of symptoms to life events rather than physical causes, the involvement of relatives and carers in consultations, and reflecting on the doctor’s own negative countertransference. Although such advice can be helpful at times (although probably not as helpful as its
proponents claim), it never seems to work with genuine career patients. Probably they have too much invested in their career to exchange it for an alternative one, however persuasively this is proposed. As for the idea that there may be a skilled psychologist or therapist somewhere who can permanently transform their understanding of themselves into a more compliant mode: I shall believe it when I see it.

The big question in dealing with career patients, I suspect, is whether it is possible to hold on to a genuine sense of respect for them, as opposed to using the label as an excuse for dismissal or contempt. One reason for respect is that they are not doing something meaningless. Quite the contrary, their pursuit of medical care fills their lives with purpose. They have an occupation that is just as absorbing as many far more respectable ones and may in fact be less of a drain on the public purse than some others, such as opera-singing. In any case, it is possible that we might end up paying even more for the social consequences of making them redundant. Their job exposes them to genuine risks, but so do many other jobs that we admire. However, the most important reason for respecting them is that their profession is in a complementary relationship with ours: they strive to sustain our existence as we do theirs. Like career patients, doctors too can be devoted to the search for simplistic answers to complex and unfathomable human problems. We are, in a sense, co-dependent.

In the end, the only way we may be able to have any impact on career patients is by accepting their right to pursue their life’s work freely. Working on this principle, the GP who presented the case I described has now reduced his patient’s regular appointments from weekly to bi-monthly intervals, and is issuing repeat prescriptions on demand, except where he feels he is putting himself at risk medico-legally. I sincerely doubt that his withdrawal from co-dependence will make things worse. It is just conceivable that it might make them better.

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References