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Caring for VIPs: Nine principles

ABSTRACT

Caring for very important persons (VIPs), including celebrities and royalty, presents medical, organizational, and administrative challenges, often referred to collectively as the "VIP syndrome." The situation often pressures the health care team to bend the rules by which they usually practice medicine. Caring for VIP patients requires innovative solutions so that their VIP status does not adversely affect the care they receive. We offer nine guiding principles in caring for VIP patients.

KEY POINTS

Caring for VIPs creates pressures to change usual clinical wisdom and practices. But it is essential to resist changing time-honored, effective clinical practices and overriding one's clinical judgment.

Designating a chairperson to head the care of a VIP patient is appropriate only if the chairperson is the best clinician for the case.

Although in some cases placing a VIP patient in a more private and remote setting may be appropriate, the patient is generally best served by receiving critical care services in the intensive care unit.

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MEDICAL TOURISM is on the rise,[1] and since medical tourists are often very important persons (VIPs), hospital-based physicians may be more likely to care for celebrities, royalty, and political leaders. But even in hospitals that do not see medical tourists, physicians will often care for VIP patients such as hospital trustees and board members, prominent physicians, and community leaders.[2–4]

However, caring for VIPs raises special issues and challenges. In a situation often referred to as the "VIP syndrome,"[5–9] a patient's special social or political status—or our perceptions of it—induces changes in behaviors and clinical practice that create a "vicious circle of VIP pressure and staff withdrawal"[9] that can lead to poor outcomes.

Based on their experience caring for three American presidents, Mariano and McLeod[7] offered three directives for caring for VIPs:

- **V**ow to value your medical skills and judgment
- **I**ntend to command the medical aspects of the situation
- **P**ractice medicine the same way for all your patients.[7]

In this paper, we hope to extend the sparse literature on the VIP syndrome by proposing nine principles of caring for VIPs, with recommendations specific to the type of VIP where applicable.

PRINCIPLE 1: DON'T BEND THE RULES

Caring for VIPs creates pressures to change usual clinical wisdom and practices. But it is essential to resist changing time-honored, effective clinical judgment and practices.

To preserve usual clinical practice, clinicians must be constantly vigilant as to whether their judgment is being clouded by the circumstances. As Smith and Shesser noted in 1988, "Since the standard operating procedures […] are designed for the efficient delivery of high-quality care, any deviation from these procedures increases the possibility that care may be compromised."[5] In other words, suspending usual practice when caring for a VIP patient can imperil the patient.[2–5,10,11] When caring for VIP physicians, for example, circumventing usual medical and administrative routines and the difficulties that caring for colleagues poses for nurses and physicians have led to poor medical care and outcomes, as well as to hostility.[2–4]

A striking example of the potential effects of VIP syndrome is the death of Eleanor Roosevelt from miliary tuberculosis acutissima: she was misdiagnosed with aplastic anemia on the basis of only the results of a bone marrow aspirate study, and she was treated with steroids. The desire to spare this VIP patient the discomfort of a bone marrow biopsy, on which tuberculous granulomata were more likely to have been seen, caused the true diagnosis to be missed and resulted in the administration of a hazardous medication.[11] The hard lesson here is that we must resist the pressure to simplify or change customary medical care to avoid causing a VIP patient discomfort or putting the patient through a complex procedure.

We recommend discussing these issues explicitly with the VIP patient and family at the outset so that everyone can appreciate the importance of usual care. An early conversation can communicate the clinician's experience in the care of such patients and can be reassuring. As Smith and Shesser noted, "Usually, the VIP is relieved if the physician states explicitly, 'I am going to treat you as I would any other patient.' "[5]

PRINCIPLE 2: WORK AS A TEAM, NOT IN 'SILOS'

Teamwork is essential for good clinical outcomes,[12–14] especially when the clinical problem is complex, as is often the case when people travel long distances to receive care. All consultants involved in the patient's care must not only attend to their own clinical issues but also communicate amply with their colleagues.

At the same time, we must recognize that medical practice "is not a committee process; it must be clear at all times which physician is responsible for directing clinical care."[5] One physician must be in charge of the overall care. Seeking the input of other physicians must not be allowed to diffuse responsibility. The primary attending physician must speak with the consultants, summarize their views, and then communicate the findings and the plan of care to the patient and family.

Paradoxically, teamwork can be challenged when circumstances lead consultants to defer communicating directly with the family in favor of the primary physician's doing so. Similarly, consultants must avoid any temptation to simply "do their thing" and not communicate with one another, thereby potentially offering "siloed," discoordinated care.

We propose designating a primary physician to take charge of the care and the communication. This physician must have the time to talk with each team member about how best to communicate the individual findings to the patient and family. At times, the primary physician may also ask the consultants to communicate directly with the patient and family when needed.

The challenges of transporting VIP patients for tests or therapy demand increased communication

PRINCIPLE 3: COMMUNICATE, COMMUNICATE, COMMUNICATE

As a corollary of principle 2, heightened communication is essential when caring for VIP patients. Communication should include the patient, the family, visiting physicians who accompany the patient, and the physicians providing care. Communicating with the media and with other uninvolved individuals is addressed in principle 4.

The logistic and security challenges of transporting VIP patients through the hospital for tests or therapy demand increased communication. Scheduling a computed tomographic scan may involve arranging an off-hours appointment in the radiology department (to minimize security risks and disruption to other patients' schedules), assuring the off-hours availability of allied health pro-

viders to accompany the patient, alerting hospital security, and discussing the appointment with the patient and the patient's entourage.

PRINCIPLE 4: CAREFULLY MANAGE COMMUNICATION WITH THE MEDIA

Although the news media and the public may demand medical information about patients who are celebrities, political luminaries, or royalty, the confidentiality of the physician-patient relationship must be protected. The release of health information is at the sole discretion of the patient or a designated surrogate.

The care of President Ronald Reagan after the 1981 assassination attempt is a benchmark of how to release information to the public.[10] A single physician held regularly scheduled press conferences, and these were intentionally held away from the site of the President's care.

Designating a senior hospital physician to communicate with the media is desirable, and the physician-spokesperson can call on specialists from the patient care team (eg, a critical care physician), when appropriate, to provide further information.

Protect confidentiality, despite the demand for information by news media

Early implementation of an explicit and structured media communication plan is advisable, especially when the VIP patient is a political or royal figure for whom public clamor for information will be vigorous. A successful communication strategy balances the public's demand for information with the need to protect the patient's confidentiality.

PRINCIPLE 5: RESIST 'CHAIRPERSON'S SYNDROME'

"Chairperson's syndrome"[5] is pressure for the VIP patient to be cared for by the department chairperson. The pressure may come from the patient, family, or attendants, who may assume that the chairperson is the best doctor for the clinical circumstance. The pressure may also come from the chairperson, who feels the need to "take command" in a situation with high visibility. Nevertheless, designation of a chairperson to care for a VIP patient is appropriate only when the chairperson is indeed the clinician who has the most expertise in the patient's clinical issues.

As in principle 1, in academic medical centers, we encourage the participation of trainees in the care of VIP patients because excluding them could disrupt the usual flow of care, and because trainees offer a currency and facility with the nuances of hospital practice and routine that are advantageous to the patient's care.

PRINCIPLE 6: CARE SHOULD OCCUR WHERE IT IS MOST APPROPRIATE

Decisions about where to place the VIP patient during the medical visit can fall victim to the VIP syndrome if the expectations of the patient or family conflict with usual clinical practice and judgment about the optimal care venue.

For example, caring for the patient in a setting away from the mainstream clinical environment may offer the appeal of privacy or enhanced security but can under some circumstances impede optimal care, including prolonging the response time during emergencies and disrupting the optimal care routine and teamwork of allied health providers.

Critical care services and monitoring are best provided in the intensive care unit, and attempts to relocate the patient away from the intensive care unit should be resisted. We recommend a candid discussion of the importance of keeping the patient in the intensive care unit to ensure optimal care by a seasoned clinical team with short response times if urgencies should arise.

At the same time, a request to transfer a VIP patient to a special setting designed for private care with special amenities (eg, appealing room decor, adjacent sleeping rooms for family members, enhanced security) available in some hospitals[15–16] can be honored as soon as the patient's condition permits. The benefits of such amenities are often greatly appreciated and can reduce stress and thereby promote recovery. The benefits of enhanced security in sequestered venues may especially drive the decision to move when clinically prudent (see principle 7).

PRINCIPLE 7: PROTECT THE PATIENT'S SECURITY

Providing security is another essential part of caring for VIPs, especially celebrities, political figures, and royalty. Protecting the patient

from bodily harm requires special attention to the patient's location, caregiver access, and other logistic matters.

As indicated in principle 6, the patient's clinical needs are paramount in determining where the patient receives care. If the patient requires care in a mainstream hospital location such as the intensive care unit, modifications of the unit may be needed to alter access, to accommodate security personnel, and to restrict caregivers' access to the patient. Modifications include structural changes to windows, special credentials (eg, badges) for essential providers, arranging transports within the hospital for elective procedures during off-hours, and providing around-the-clock security personnel near the patient.

As important as it is to protect VIP patients from bodily harm during the visit, it is equally important to protect them from attacks on confidentiality via unauthorized access to the electronic medical record, and this is perhaps the more difficult challenge, as examples of breaches abound.[10,17–19] Although the duty to protect against these breaches rests with the hospital, the use of "pop-ups" in the electronic medical record can flash a warning that only employees with legitimate clinical reasons should access the record. These warnings should also cite the penalties for unauthorized review of the record, which is supported by the Health Insurance Portability and Accountability Act (HIPAA). Access to celebrities' health records could be restricted to a few predetermined health care providers.

PRINCIPLE 8: BE CAREFUL ABOUT ACCEPTING OR DECLINING GIFTS

VIP patients often present gifts to physicians, and giving gifts to doctors is a common and long-standing practice.[20,21] Patients offer gifts out of gratitude, affection, desperation, or the desire to garner special treatment or indebtedness. VIP patients from gifting cultures may be especially likely to offer gifts to their providers, and the gifts can be lavish.

The "ethical calculus"[21] of whether to accept or decline a gift depends on the circumstances and on what motivates the offer, and the physician needs to consider the patient's reasons for giving the gift.

In general, gifts should be accepted only with caution during the acute episode of care. The acceptance of a gift from a VIP patient or family member may be interpreted by the gift-giver as a sort of unspoken promise, and this misunderstanding may strain the physician-patient relationship, especially if the clinical course deteriorates.

Rather than accept a gift during an episode of acute care, we suggest that the physician graciously decline the gift and offer to accept the gift at the end of the episode of acute care—that is, if the offerer still feels so inclined and remembers. Explaining the reason for deferring the gift can decrease the risk of misunderstandings or of unmet expectations by the gift-giver. Also, deferring the acceptance of a gift allows the caregiver to affirm the commitment to excellent care that is free of gifts, thereby ensuring that the patient will be confident of a similar level of care by providers who have not been offered gifts.

On the other hand, declining a gift may cause more damage than accepting it, particularly if the VIP patient is from a culture in which refusing a gift is impolite.[22] A sensible compromise may be to adopt the recommendations of the American Academy of Pediatrics[23]—ie, attempt to appreciate appropriate gifts and graciously refuse those that are not.

Declining a gift may cause more damage than accepting it if the patient is from a culture in which refusing gifts is impolite

PRINCIPLE 9: WORKING WITH THE PATIENT'S PERSONAL PHYSICIANS

VIP patients, perhaps especially royalty, may be accompanied by their own physicians and may also wish to bring in consultants from other institutions. Though this outside involvement poses challenges (eg, providing access to medical records, arranging briefings, attending bedside rounds), we believe it should be encouraged when the issue is raised. Furthermore, institutions and caregivers should anticipate these requests and identify potential outside consultants whose names can be volunteered if the issue arises.

Again, if VIP patients wish to involve physicians from outside the institution where they are receiving care, this should not be viewed as an expression of doubt about the care being received. Rather, we prefer to view it as an opportunity to validate current management

or to entertain alternative approaches. Most often, when an outside consultant confirms the current medical care, this can have the beneficial effect of increasing confidence and facilitating management.

In a similar way, when VIP patients bring their own physician, whose judgment and care they trust, this represents an opportunity to engage the patient's trusted physician-advisor in clinical decision-making and thus optimize communication with the patient. Collegial interactions with these physician-colleagues can facilitate communication and decision-making for the patient.

REFERENCES

1. **Ehrbeck T, Guevara C, Mango PD**. Mapping the market for medical travel. Health Care: Strategy & Analysis. McKinsey Quarterly 2008 May; 1–11.
2. **Stoudemire A, Rhoads JM**. When the doctor needs a doctor: special considerations for the physician-patient. Ann Intern Med 1983; 98:654–659.
3. **Schneck SA**. "Doctoring" doctors and their families. JAMA 1998; 280:2039–2042.
4. **Adshead G**. Healing ourselves: ethical issues in the care of sick doctors. Adv Psychiatr Treat 2005; 11:330–337.
5. **Smith MS, Shesser RF**. The emergency care of the VIP patient. N Engl J Med 1988; 319:1421–1423.
6. **Block AJ**. Beware of the VIP syndrome. Chest 1993; 104:989.
7. **Mariano EC, McLeod JA**. Emergency care for the VIP patient. Intensive Care Medicine 2007. http://dx.doi.org/10.1007/978-0-387-49518-7_88. Accessed December 27, 2010.
8. **Schenkenberg T, Kochenour NK, Botkin JR**. Ethical considerations in clinical care of the "VIP". J Clin Ethics 2007; 18:56–63.
9. **Weintraub W**. "The VIP syndrome": a clinical study in hospital psychiatry. J Nerv Ment Dis 1964; 138:181–193.
10. **Weiss YG, Mor-Yosef S, Sprung CL, Weissman C, Weiss Y**. Caring for a major government official: challenges and lessons learned. Crit Care Med 2007; 35:1769–1772.
11. **Lerner BH**. Revisiting the death of Eleanor Roosevelt: was the diagnosis of tuberculosis missed? Int J Tuberc Lung Dis 2001; 5:1080–1085.
12. **Lee TH**. Turning doctors into leaders. Harv Bus Rev 2010; 88:50–58.
13. **Clemmer TP, Spuhler VJ, Berwick DM, Nolan TW**. Cooperation: the foundation of improvement. Ann Intern Med 1998; 128:1004–1009.
14. **Morey JC, Simon R, Jay GD, et al**. Error reduction and performance improvement in the emergency department through formal teamwork training: evaluation results of the MedTeams project. Health Serv Res 2002; 37:1553–1581.
15. **VIP ward at Walter Reed gets scrutiny**. USA Today. http://www.usatoday.com/news/washington/2007-03-15-walter-reed-vip_N.htm. Accessed December 27, 2010.
16. **Robins RS, Post JM**. When Illness Strikes the Leader. The Dilemma of the Captive King. New Haven: Yale University Press; 1995.
17. **Carr J**. Breach of Britney Spears patient data reported. SC Magazine, March 19, 2008. http://www.scmagazineus.com/breach-of-britney-spears-patient-data-reported/article/108141/. Accessed December 27, 2010.
18. **Collins T**. Sir Bobby Robson's electronic health records viewed illicitly by NHS staff. ComputerWeekly.com, September 24, 2007. http://www.computerweekly.com/blogs/tony_collins/2007/09/bobby-robsons-medical-records-1.html. Accessed December 27, 2010.
19. **Ornstein C**. Kaiser hospital fined $250,000 for privacy breach in octuplet case. Propublica.org, May 15, 2009. http://www.propublica.org/article/kaiser-hospital-fined-250000-for-privacy-breach-in-octuplet-case-515. Accessed December 27, 2010.
20. **Levene MI, Sireling L**. Gift giving to hospital doctors—in the mouth of the gift horse. Br Med J 1980; 281:1685.
21. **Lyckholm LJ**. Should physicians accept gifts from patients? JAMA 1998; 280:1944–1946.
22. **Takayama JI**. Giving and receiving gifts: one perspective. West J Med 2001; 175:138–139.
23. **Committee on Bioethics**. From the American Academy of Pediatrics: policy statements—pediatrician-family-patient relationships: managing the boundaries. Pediatrics 2009; 124:1685–1688.

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