Thomas Schenkenberg, Neil K. Kochenour, and Jeffrey R. Botkin, "Ethical Considerations in Clinical Care of the 'VIP'," *The Journal of Clinical Ethics* 18, no. 1 (Spring 2007): 56-63.

Ethical Considerations in Clinical Care of the "VIP"

Thomas Schenkenberg, Neil K. Kochenour, and Jeffrey R. Botkin

Thomas Schenkenberg, PhD, is a Professor in the Department of Neurology at the University of Utah School of Medicine in Salt Lake City, Utah, *thomas.schenkenberg@hsc.utah.edu.*
Neil K. Kochenour, MD, is a Professor in the Department of Obstetrics and Gynecology and Medical Director at University Hospitals and Clinics at the University of Utah School of Medicine.
Jeffrey R. Botkin, MD, is a Professor in the Department of Pediatrics and Division of Ethics and Associate Vice President for Research at the University of Utah School of Medicine.

The illnesses and injuries of celebrities are daily fare in the public media and most experienced clinicians can recount personal encounters with celebrity "VIP" patients. While obvious ethical violations with regard to confidentiality may occur simply as a result of the temptation to impress others, more complex, unrecognized ethical challenges can arise due to conflicts between legitimate, but competing, values and goals. The majority of these ethical issues arise when the clinician's standard approach is significantly altered as a result of the VIP's social status rather than being determined by the clinical features of the presenting situation.

"VIP," an acronym that typically translates to "very important person," would be more usefully understood, in the clinical context, as "very *influential* person." The word "important" indicates valid and inherent significance, consequence, or value. Whether a given celebrity is "important" depends on whether the requirements of the definition of "important" are met. The word "influential" indicates that an effect has been exerted on others. In the clinical context, the effect would be a significant change in the clinical approach.

A working definition of a "medical VIP" is suggested as follows.

- Any individual whose personal (non-clinical) characteristics significantly change the clinical approach of the clinician, or
- Any individual whose clinical or personal characteristics are such that the clinician's personal interests or the interests of others produce a significant alteration in the patient's care. We add this second element to account for the special care provided to patients with conditions that are of personal interest to a particular clinician or when treating a patient in a preferential manner could produce a beneficial effect for others.

This definition is very broad and, indeed, any given patient might have an idiosyncratic characteristic that could unduly influence a given clinician. It is the potential ubiquity of these influences that points to the need for reflection and analysis.

Although alterations in the standard of care for a celebrity VIP would typically be intended to result in superior care, a medical VIP's non-clinical characteristics (for example, expressed racism) could affect the clinician's approach in a negative way and could incline a given clinician to provide a lesser standard of care than is customary. Of course, some alterations in the standard of care that are intended to be beneficial, may, in fact, not be beneficial.

THE CUSTOMARY STANDARD OF CARE AND EXAMPLES OF ALTERATIONS IN THE STANDARD OF CARE FOR VIPS

The experienced clinician's standard approach for providing optimal clinical care has been developed on the basis of hard-won training and experience. Of course, practitioners commonly adjust their standard protocol because of special clinical considerations. Many social and regulatory forces also influence care, for example, the Health Insurance Portability and Accountability Act (HIPAA), the Emergency Medical Treatment and Active Labor Act (EMTALA), institutional policy, the requirements of third-party payers, accreditation guidelines, and quality assurance concerns. The focus here is on changes made in care that are based on the patient's VIP status.

Clinicians and institutional administrators commonly make "accommodations" with regard to meals, special rooms, and conveniences for celebrity patients and benefactors.[1] Accommodations for celebrity VIPs may also include matters that are directly related to clinical care, such as the seniority of attending staff, special support personnel, scheduling of diagnostic studies, scheduling surgery, and avoiding students' participation in providing care.

Changes in the standard protocol might also occur as a result of interaction between clinical issues and the personal interests of the clinician, or the interests of others. For example, a clinician with a personal interest in a certain disease might make special arrangements (outside a research protocol) for a patient with the condition.

To the uninitiated, including the celebrity VIP, it may appear that there are only advantages associated with being a VIP patient. However, certain important disadvantages can also accrue. The history or physical exam may be less thorough than for the typical patient.[2] The VIP may receive excessive or fewer diagnostic studies. The VIP may be undertreated or overtreated in a manner that varies from the customary.[3] The usual confidentiality rules might be held in abeyance. Self-indulgent demands by the VIP may lead to physician-assisted substance abuse because the clinician does not or cannot effectively counter the demands.

The VIP's pursuit of multiple opinions or the "ultimate expert" can complicate care. The Ayatollah Khomeini was said to have been attended by 40 Iranian physicians. In 1979 the exiled, self-proclaimed Shahanshah of Iran received medical care from eight medical teams from six countries. At the time of Francisco Franco's death, one attending physician observed that there were so many physicians in the hospital room that there was scarcely room for the patient.[4] The VIP's pursuit of the highest ranking or most well-known clinician may not result in identifying the most qualified clinician. The intervention of a high ranking clinician in caring for the VIP, when the high ranking clinician is not regularly involved in the type of technical care required, has been called the "chief syndrome."[5] This type of upward transfer of clinical authority within a hospital hierarchy might be encouraged by high-level administrative personnel who may attempt to influence frontline clinicians with requests for preferential care for a VIP.[6]

Case reports describing the care of "famous patients" demonstrate that medical and surgical care has been delayed due to social and political considerations. Public statements, as well as information given to the VIP patient, have been postponed and deceptive. For example, Evita Perón was described as the "victim of the VIP syndrome" in the misdiagnosis of her cervical cancer and the failure to inform her of her diagnosis.[7] In 1985, amidst significant political turmoil, delayed surgical interventions (eventually seven in number) for diverticulitis by "rival teams of surgeons" for Brazilian President-Elect Tancredo Neves led to the conclusion that "he died of high status."[8] It has been argued that the demands of high political office compromise the quality of medical care and that being a political VIP can be dangerous "not only for the health of the

leader but also for the well-being of the nation," as in the case of delayed hospitalization for President Dwight David Eisenhower, after his left anterior wall myocardial infarction in 1955.[9] The anticipated, potential negative effect on the public of news of certain types of illnesses in political figures has resulted in the observation that there is a medical-political paradox: "to get the best medical treatment can be politically fatal, to subordinate medical considerations to political considerations can be medically fatal."[10]

While associates of the celebrity VIP may rush to gain access to special medical/surgical care for the celebrity, psychiatric problems may be ignored or denied in their earlier stages or even deceptively referred to as "exhaustion."[11] This, in turn, may lead to delayed or inferior quality mental health care for celebrities, followed by frantic efforts to secure exceptional care when psychiatric symptoms become too severe to ignore.[12]

The literature also points to special categories of VIPs such as "the doctor as patient," which produce significant alterations in the quality of care.[13] One anecdotal report describes a prominent physician who reportedly taped a note to his chest prior to an operation at his own hospital saying that he wanted to be treated just like anybody else.[14]

ETHICAL CONSIDERATIONS

Achieving excellent treatment for one's patient, advancing knowledge, improving medical training, increasing financial support for an institution, engendering a positive public image for an institution, enhancing societal well-being, and advancing ones's personal career are all accepted, legitimate goals. Ethical conflicts arise in the care of the medical VIP when those goals compete with each other or compete with other positive goals such as maintaining a proper standard of care for all patients, proceeding with care on the basis of truly informed consent, honoring the principle of distributive justice, avoiding conflicts of interest, and, of course, maintaining patients' confidentiality. We will discuss two milieus, the emergency department and psychiatric settings, in which ethical issues related to the care of the VIP have been debated in the literature. We will then review general ethical considerations related to the VIP, to other patients, to the clinician, and, finally, with regard to institutional and societal impact.

EMERGENCY DEPARTMENT

Many authors have found preferential care for VIPs in the emergency department to be unacceptable because the nature of the care may be based on social status rather than clinical need, and would thus fail "the test of fairness."[15] Such special care in the emergency department may harm other patients due to longer waiting times and increased discomfort and risk as they wait. If a celebrity VIP or healthcare administrator receives special care in the emergency department, she or he will not appreciate the average patient's experiences. This inherent dishonesty "robs other emergency department users of the benefits that might occur were VIPs subjected to visits more like theirs."[16] In the long run, the system fails to benefit from the feedback that might come from those who are in the best position to effect change.[17]

Conversely, it has been argued that care of the celebrity VIP in an emergency room setting *should* include special accommodations due to the special needs of the VIP and to maintain the standard of care for other patients. Suggested accommodations include having a senior physician take control of the situation when the VIP is seriously ill, calling in additional staff, admitting a VIP to in-patient care when an ordinary patient would not be admitted, and possibly diverting regular patients to other facilities.[18]

Most authors conclude that, with regard to care in the emergency department, the best care is routine care. The care received by Ronald Reagan following a 30 March 1981 assassination attempt and the care received by Pope John Paul II following a 14 May 1981 assassination attempt have been described as very similar to the care that would have been provided in the respective emergency rooms of George Washington University Hospital and Gemelli Hospital for any person with a gunshot wound; the care they received has been described as a model of how VIP care should be conducted in the emergency department.[19]

PSYCHIATRIC SETTINGS

Applying the principle that "the best care is routine care" may not be possible or advisable when the VIP's care is provided in other settings.[20] For example, an in-patient psychiatric hospitalization involves a longer length of stay, more complex interactions with numerous staff, more group activities, and represents different challenges from those found in the emergency department.[21]

The presence of a VIP in an in-patient psychiatric unit can have considerable, negative effect on the staff, other patients, and the therapeutic milieu. As a result, other patients and the VIP himself or herself may not receive optimal treatment because of alterations in the fundamental nature of the milieu, patient-to-patient relationships, and staff-to-patient relationships. Celebrity VIPs in a psychiatric setting or in longer term medical settings may suffer an even greater loss of self-esteem and loss of control than the typical patient, and the resulting dependency, loss of influence, and passivity may be especially troublesome to them.[22] Treatment of unusually influential patients, including physicians, in a psychiatric hospital has led to another use of the term "VIP syndrome," that is, a pattern that involves increased pressure on the treating staff (sometimes created by the desires/expectations of the staff themselves rather than by the patient), isolation of the patient, increased demands by the patient, and "very likely eventual therapeutic failure," with suicides and premature discharge against medical advice.[23] The in-patient psychiatric treatment of Ernest Hemingway when he was ill with a paranoid alcoholic depression at the age of 62 was described as overly personal and as treating Hemingway as "the very famous author" rather than as "the very ill patient."[24] Such overly personal interaction between the staff and the patient may have inadvertently contributed to Hemingway's eventual suicide four days after discharge from a second hospitalization.[25] The "special" care of Secretary of State James F. Forrestal's severe psychiatric disorder (depression, paranoia, and suicide threats) involved less aggressive treatment and less supervision than was typical in that era and may have contributed to Forrestal's suicide by jumping from a VIP tower suite on the sixteenth floor of the Bethesda Naval Hospital in 1949, a room that was not equipped to house suicidal patients.[26]

EFFECTS ON THE VIP

Clearly, when "special" care for the medical VIP results in worse care (intended or unintended) for the VIP, the stated purpose of care has been compromised. Such a possible outcome of "special" care is rarely openly recognized and perhaps never discussed with the patient. The nature of a true "informed consent" discussion with a VIP in this regard, that is, outlining the possible risks of "special" care, would be difficult; although, in principle, such a patient should be apprised of the increased risks associated with care that deviates from the norm.

In attempting to achieve a proper standard of care for the VIP, it is clear that, at times, the needs of the VIP actually exceed the needs of the typical patient, and the clinical process should be adjusted accordingly. For example, caring for a VIP raises special considerations with regard to confidentiality.[27] Ideally, the VIP has the same right to confidentiality as other patients. When the VIP patient is a serial killer or an impaired head of state, the responsibilities of the clinician with regard to confidentiality become very complex.[28] Deception has often been employed in actions and statements concerning the healthcare and health status of VIPs, especially heads of state.[29] Remarkable attempts have been made by unauthorized individuals to acquire medical records, lab results, blood samples, and even slides of fecal matter related to famous and infamous patients, and significant inducements have been offered to staff to take photographs of VIP patients or their remains.[30] Accomplishing a proper level of confidentiality for the VIP requires additional vigilance, effort, and planning on the part of individual staff members and institutions.

While there may be potentially negative issues related to public discussion of a VIP's care, with the VIP's permission, publicity about his or her illness may instead produce positive results. Many celebrity VIPs choose to disclose personal medical information. A great deal of attention has been focused on the disease entities associated with Lance Armstrong, Kitty Dukakis, Michael J. Fox, and Betty Ford. This attention led to increased research and institutional funding, early diagnosis for other patients, improved

education for individual patients, better public understanding, and greater compassion for those suffering from the condition.

EFFECTS ON OTHER PATIENTS

Beyond the interests of the VIP, the care of the "ordinary" patient can be affected when the clinician alters his or her pattern of care for a VIP. If the VIP is allowed to "jump the queue" for an appointment or other services, other patients will be displaced and their care might be delayed or restricted, and they will not be informed that their care has been adversely affected in favor of the VIP's care.

EFFECTS ON THE CLINICIAN

Clinicians may be sorely tempted to discuss what they know about the status of a VIP under their care. Indeed, when the issue of VIP care is raised, it is common for clinicians to volunteer stories about VIPs they have seen in the past. In the extreme, this behavior has been referred to as the "star-struck phenomenon," with clinicians so influenced by their own acquired, secondary celebrity status that they have broken confidentiality, apparently for reasons related to their own need for increased status.[31]

Special treatment or the expectations of special treatment from any source for a VIP may also affect staff morale. Staff may resent being asked to participate in the exceptions granted to VIPs because such "special" treatment stands in contrast to their value of "equal treatment for everyone." While some staff may seek inappropriately close association with a VIP, others often describe a VIP in unflattering terms, speak of the burden involved in caring for a VIP, and express relief when a VIP's care is completed.[32]

The care of high ranking political figures carries a wide variety of potential conflicts and risks for the clinician, ranging from demands for inappropriate care, demands for deception, potential loss of prestige for failing to participate (thus "losing" the high status patient), conflicting lines of authority for decisions, and even death, as in the case of Bernhard von Gudden, Ludwig II's psychiatrist, who drowned with his patient under mysterious circumstances in 1886.[33]

INSTITUTIONAL/SOCIETAL IMPACT

The impact of the VIP's requests or needs on the care of other patients often depends on the ability of an institution to manage the administrative complexities created by having a VIP in the facility. For smaller institutions, treating a celebrity VIP is a unique experience. Such institutions may have no formalized plan for handling a celebrity VIP and thus must develop an approach specific to the unique situation that they find themselves in.[34] Using our definition of a medical VIP, however, the presence of a VIP is not particularly uncommon, and, thus, it might be suggested that all institutions, large and small, should be prepared for the ethical challenges of the medical VIP.

The expense involved in accommodating a VIP's additional needs with regard to confidentiality and security represents additional challenges in terms of organizational ethics. Hospital personnel need explicit directions about any special confidentiality requirements of the VIP. Some institutions have standardized plans for dealing with the media on issues related to celebrity patients.[35] Such plans are reported to minimize the disruption of the regular function of the facility and minimize disruption to the care of other patients, which could occur in the face of thousands of letters and messages to the celebrity, the presence of numerous credentialed and uncredentialed media personnel, and requirement for heightened security.[36]

Institutions have the option of "overstaffing" to accommodate a VIP's requests. Passing these costs for extra care to the VIP, rather than dispersing them to all patients, is a meritorious approach. Developing policies to guide such practices has the advantage of a transparent discussion of the issues and their effects.

Extra consideration for a VIP may lead to the promotion of worthy social goals. Alternatively, as noted above, it has been argued, although not tested, that patients in general will benefit more if a celebrity VIP patient experiences the type of care available to everyone, thus becoming aware of the need for improvement in the delivery of care, with the informed celebrity being in a better position to work for improved care for

all.[37] Philanthropy for medical or academic institutions is often fostered when wealthy individuals or their loved ones receive outstanding care.

Some authors have proposed that there may be rare circumstances in which special clinical care for a VIP could have beneficial clinical effects for a large number of people in general, and thus the special care might be justified.[38] For example, it has been proposed that special treatment for a high ranking political figure during a national crisis or for key medical personnel during an epidemic may be justified on the basis of the secondary impact on the welfare of others.[39] Once one opens this line of reasoning concerning the needs of third parties, however, one must be prepared to deal with a very wide range of possible justifications for altering the care of the patient at hand. For example, should the needs of a single mother of four, whose children would benefit if she received preferential care, be given priority over care of an elderly widower?

CONCLUSIONS AND RECOMMENDATIONS

- Special care for a VIP is improper if it results in worse care for the VIP. The potential for unintentionally causing worse care requires special vigilance on the part of the clinician.
- If a significant alteration in the standard of care for a VIP is contemplated, those changes should be reviewed with the VIP. Informing a VIP that he or she will *not* receive "special" care could be advantageous.
- Special care, provided for non-clinical reasons, for a VIP is morally unacceptable if it results in worse care for other patients.
- Possible future benefit to the community, to other patients, or to the institution for treating a VIP in a special manner must be evaluated in the context of the immediate impact on the care of others whose access to care is determined by medical need and fairness. Accommodating VIPs for the purpose of increasing the likelihood of continued or future financial support for the institution or as a reward for past contributions might be justified, as long as other patients are not harmed by the specific measures involved. Benefactors should not assume that they have "paid in advance" for special care if such care comes at the expense of significantly worse care for another patient.
- The increased needs of VIPs with regard to protecting privacy, security, and confidentiality should be recognized.[40] The costs of these accommodations represent a significant challenge to institutional ethics and policy and should not be passed on to regular patients.
- As a result of their VIP status, celebrity VIPs may actually require clinical care that is different from the standard, as in the case of in-patient psychiatric care. The care of other patients may need to be adjusted beyond the typical standard of care to offset the impact of the presence of the VIP.
- Family/entourage and media influence must be managed with the rights of the patient being paramount.
- The development of institutional policy or a VIP protocol would result in a healthy discussion of the ethical issues involved in the care of the medical VIP.
- Institutional policy should include "blinding" the decision-making process with regard to clinically irrelevant social variables, for example when prioritizing transplant candidates.[41]
- Consultation with the hospital ethics committee may be beneficial if opposing values and viewpoints are difficult to resolve.

The present discussion relates to values that have emerged in contemporary society in the United States, where the general standard of care is high. There is always a degree of "unevenness" in the application of clinical care across patients, across units, and across institutions; but, within an institution, one would hope that such unevenness is not deliberately based on non-clinical factors if harm comes to the patient as a result.

Finally, while anecdotal accounts of celebrity VIP care appear in the literature, there has been very little objective study of the impact of a medical VIP's status on the care he or she receives, on the care that other patients receive, or on the institution. A number of issues might fruitfully be explored, including the types of medical VIPs that produce significant change in the standard of care, how the standard of care is changed,

special issues related to confidentiality, risks to VIPs and to regular patients, and whether factors such as the gender of the VIP influence care and institutional preparations for VIPs.

ACKNOWLEDGMENTS

The authors would like to thank Anne Brillinger, James R. Scott, MD, and Judith E.A. Warner, MD, for their helpful comments on the manuscript.

FINANCIAL SUPPORT

No financial support was provided for this article.

NOTES

1. K. Douglass, "Madonna Slept Here," *Hospital Health Network* 71, no. 14 (1997): 61.
2. D.S. Diekema, "It's Wrong to Treat VIPs Better than Other Patients," *ED Management* (2000): 92-3.
3. R.E. Strange, "The VIP with Illness," *Military Medicine* (1980): 473-5.
4. J.M. Post and R.S. Robbins, *When Illness Strikes the Leader* (New Haven: Yale University Press, 1993); M. Bloom, "The Pahlavi Problem: A Superficial Diagnosis Brought the Shah into the United States," *Science* 207 (1980): 282-7.
5. M.S. Smith and R.F. Shesser, "The Emergency Care of the VIP Patient," *New England Journal of Medicine* 319, no. 21 (1988): 1421-3.
6. W. Weintraub, "The VIP Syndrome: A Clinical Study in Hospital Psychiatry," *Journal of Nervous & Mental Disease* 138 (1964): 181-93.
7. A.B. Lowenfels, "Famous Patients, Famous Operations, 2002 - Part 6: The Case of a Politician's Wife," *Medscape Surgery* 4, no. 2 (2002): 1-4.
8. C. Marwick, "Being Called to Care for the Mighty Poses Unique Challenges for Attending Physician," *Journal of the American Medical Association* 270, no. 3 (1993): 298-9.
9. Post and Robbins, see note 4 above.
10. See note 8 above.
11. Post and Robbins, see note 4 above.
12. E.H. Feuer and S.R. Karasu, "Star-struck Service: Impact of the Admission of a Celebrity to an Inpatient Unit," *Journal of Clinical Psychiatry* 39, (1978): 743-6.
13. S.A. Schneck, "Doctoring Doctors and Their Families," *Journal of the American Medical Association* 280 (1998): 2039-42.
14. Post and Robbins, see note 4 above.
15. D.S. Diekema, "The Preferential Treatment of VIPs in the Emergency Department," *American Journal of Emergency Medicine* 14, no. 2 (1996): 226-9; "What if Your ED Misdiagnoses a Public Figure? Here's How to Handle VIPs," *ED Management* (2000), *http://www.ahcpub.com/ahc_root_html/hot/archive/edm112000.html.*
16. See note 2 above; Diekema, see note 15 above.
17. Ibid.
18. L. Mellick, "VIP Patients Should Be Treated Differently," *ED Management* (2000): 90-2; see note 5 above.
19. D. Breo, *Extraordinary Care* (Chicago: Chicago Review Press, 1986).
20. See note 8 above.
21. See note 12 above.
22. See note 3 above; see note 6 above.
23. Ibid.

24. See note 3 above.
25. Ibid.
26. Post and Robbins, see note 4 above.
27. "What if Your ED Misdiagnoses a Public Figure?" see note 15 above; see note 5 above; W.H. Roach, "Legal Review: Coping with Celebrity Patients," *Topics in Health Records Management* 12, no. 2 (1991): 67-72.
28. Post and Robbins, see note 4 above.
29. Ibid.
30. See note 19 above.
31. See note 12 above.
32. See note 6 above.
33. Post and Robbins, see note 4 above; see note 6 above.
34. H. Howie, "VIPs — Handle with Care," *Health Care* (August/September 1981): 20-2.
35. Cedars-Sinai Security and the Media, "Protecting Celebrity Patients," *Hospital Security Safety Management* 15, no. 8 (1994): 1-2.
36. See note 34 above.
37. See note 2 above.
38. Diekema, see note 15 above.
39. Ibid.
40. See note 18 above.
41. "Docs moved Saudi up transplant list," *Los Angeles Times,* 28 September 2005.