NARRATIVE MEDICINE

To Pace or Not To Pace? A Narrative Review of VIP Syndrome

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PHYSICIAN STORY

"Hi, would you mind seeing my dad?"

I received an urgent call on a lovely Sunday evening from a Consultant Dermatologist, who was my excolleague. It was a brief phone consultation about her father, who had just been admitted to the Cardiology Unit for recurrent syncopes. He was strongly advised to have a pacemaker implanted. In the midst of helping her father make this major decision, my excolleague boiled it down to a very crucial question: Was it a cardiac or a neurogenic syncope?

"Certainly, I would love to see your father tomorrow at my neurology clinic," I replied. My prompt and positive response seemed to have soothed her nerves, which resulted in immediately discharging her father at her own risk from the Cardiology Unit.

She came along with her father the next day. Her father was a moderately built man in his late 50s. He was a teetotaler and a nonsmoker. His first syncopal attack happened 1 year before this consultation. The first attack was triggered by profuse vomiting and epigastric pain. He regained consciousness quickly upon arrival at the Emergency Department. Extensive investigation including a brain computed tomography (CT) was performed. The only significant finding detected was his slow regular heart rate, ranging around 40 to 50 beats per minute (bpm). The electrocardiogram at that juncture revealed sinus bradycardia with no ischemic changes. His cardiac enzymes were repeatedly within normal limits, and he denied any angina symptoms. He had no other previous significant medical history or family members with coronary artery disease. Twenty-four-hour Holter monitoring did not reveal any sinister arrhythmias. His echocardiogram was grossly normal with an ejection fraction of 60%.

He had remained well until a couple of days before my consultation with him. He reported having dizziness with a spinning sensation and a presyncopal attack, which sounded to me like vertigo. Owing to his previous history of bradycardia, he was rushed to the Cardiology Unit again for opinions. Apart from the sinus bradycardia at around 40 to 50 bpm, there were no other examination results of concern. In view of the relationship between the recurrent syncopes and bradycardia, he was advised to have a pacemaker implanted.

After obtaining the above history from the patient and confirming it with my excolleague, I proceeded with a physical examination. There were no cerebellar signs or other neurologic deficits. Otoscopy showed no abnormal findings. Other systems including the cardiovascular, respiratory, and abdominal systems were grossly normal. The electrocardiogram revealed sinus bradycardia at a rate of 50 bpm. Before I was able to sum up my findings and inform them of the most possible diagnosis, my excolleague started suggesting a plethora of plans, such as a repeated brain CT, magnetic resonance imaging, CT of the coronary arteries, an Ear, Nose, and Throat referral, a second opinion from the cardiologist, etc.

"Look, your anxiety about missing something in your father might overemphasize the work-up and subsequent treatment, which might further lead to an inferior outcome," I replied to her plans.

"Clearly, as you would concur with me, he had vertigo this time possibly because of vestibular neuritis. The first syncope was most likely caused by the vasovagal attack after the vomiting. He had a baseline heart rate of 40 to 50 bpm, and repeated monitoring did not pick up any malignant arrhythmias. I would suggest an Ear, Nose, and Throat consultation, and in the mean time, some antivertigo medications would ameliorate his partially resolving symptom …"

Her anxiety seemed to start ebbing away. Her emotional response had blurred her vision to appreciate the risks and benefits of her previously suggested management plans. She conceded that she had overreacted and downplayed my role as the attending clinician.

I told her, "Don't worry, I understand that you want to seek the best treatment for your father, which is why you are here today. And I am going to treat your father exactly like I would my other patients. The standard of care would most benefit your father."

Both the patient and his daughter were satisfied with my advice. The patient went home happily with some cinnarizine and betahistine tablets, and he refused further referrals unless he remained vertiginous.

One month later, my excolleague texted me to express her gratitude for my unbiased clinical acumen. Her dad completely recuperated without a pacemaker implantation.

DISCUSSION: VIP SYNDROME

The term VIP (very important person) syndrome was introduced by Dr Walter Weintraub in 1964.[1] Managing VIPs poses a great challenge to health care practitioners. A VIP, by definition, is a person given special privileges in view of his or her status or wealth. Examples of VIPs include royalty, politicians, celebrities, corporate leaders, and wealthy individuals. In my very humble opinion, medical personnel or their relatives have increasingly become VIPs for special treatment.

The care of VIPs is highly varied from one clinic to another because of ethical dilemmas, different perceived benefits for the VIPs, and a vastly heterogeneous group of clinicians and VIPs. VIP medicine is a seemingly insidious phenomenon. Whereas it has been believed implicitly that because of their unique status VIPs are given the best care, faster and greater access, enhanced and more convenient facilities, and special attention

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from physicians, VIP care can be singularly harmful. The late world-renowned singer Michael Jackson was unquestionably a victim of VIP medicine. He had unlimited access to propofol with the VIP services rendered by his personal physician. His physician acceded to the singer's demands to receive propofol to help him sleep, which ultimately was a cause of his death. The shocking death of the pop-star Prince opened the door to questions of whether he was an unfortunate victim of VIP syndrome. He succumbed to an accidental overdose of fentanyl. These two tragedies highlight not only the "side effects" of VIP syndrome, but also underscore the complexity of the VIP issue when treating celebrities—for example, demands by the VIPs for potentially life-threatening drugs or procedures, ethical tensions and dilemmas, and breach of heightened privacy and confidentiality when providing evidence in court.

Hospitalizing VIPs (like celebrities, politicians, and elected leaders) could make hospital staff feel uneasy, especially in a hospital that is not prepared for their admission. VIP hospitalization causes a great deal of mass-media attention. VIPs need or demand secluded areas for treatment, which could be disruptive to the care for more medically indicated, non-VIP groups of patients. Reprobate reporters trying hard to get unmediated information about VIPs' admission records or notes could cause disharmony in the hospital involved and subsequent ethical dysfunction.

To date, very scarce guidelines have been established and few empirical studies have elucidated this VIP issue. A recent survey performed in an inpatient setting revealed that a majority of the physicians in the study were under pressure by a VIP patient or his or her family members to order additional tests or treatment that were deemed medically unnecessary. Reportedly 36% of the physicians were pressured by hospital representatives to comply with the VIP demands.[2] Unnecessary investigation is often masqueraded as "more is better." Contrary to this conventional belief, this may do more harm. For example, by exposing an individual with no indications to radiation injury by doing a CT scan; by causing emotional stress and fear after detection of slightly elevated blood levels, false positives, or mildly raised cancer markers in an asymptomatic patient; or by inappropriate escalation of an antibiotic to a more broad-spectrum class drug may result in antibiotic resistance. In clinics with limited resources, health budgets, and medical facilities, such practice of care inequities may deprive non-VIP patients of standardized care.

Guzman et al[3] offer 9 principles in handling VIPs that are handy and worth reading. Principle 1: Don't bend the rules. Any deviation of clinical practice when caring for a VIP can compromise delivery of the right care. Principle 2: Work as a team, not in "silos." Teamwork is crucial in ensuring good clinical outcomes. Principle 3: Communicate, communicate, communicate. Heightened communication should include the patient, family, and other health staff members involved in providing care. Principle 4: Carefully manage communication with the media. Confidentiality in the physician-patient relationship must be guarded. Principle 5: Resist "chairperson's syndrome." Chairperson's syndrome is pressure from the patient, family member, hospital representative, or even the VIP patient to be cared for by the department chairperson. Principle 6: Care should occur where it is most appropriate. Decisions on where to place the VIP patient should be made on the basis of the venue where the optimal care can be delivered. Principle 7: Protect the patient's security. Ensuring security is of paramount importance in managing VIP syndrome. Principle 8: Be careful about accepting or declining gifts. It is suggested that physicians decline gifts graciously to minimize unmet expectations and misunderstandings, and also affirm the care that is free of gifts. Principle 9: Work with the patient's personal physicians. Effective interactions with the VIP's personal caregivers can facilitate communication and decision making for the patient.

Of these 9 rules, I suggest that effective communication is quintessential. Engaging sustained and focused eye contact is one of the most unbelievably powerful means of communication. Listening to the patient's own account of his or her complaints and history, not fully from family members, is of paramount importance in getting to the bottom of the most possible diagnosis. As in the pacemaker case, my excolleague, who was a Consultant Physician, gave me a long list of differentials that could have unintentionally clouded my clinical acumen. Furthermore, as a specialist, she probably had formulated the most possible diagnosis for her father, which was cardiac syncope, before seeing me. Such immense pressure from a Consultant might be why our Cardiology colleagues pushed for inappropriate steps by recommending a pacemaker implantation.

Physicians providing care for a physician or a physician's family member may feel conflicted in their dual roles of colleague and practitioner. When managing a physician's family, collegial interactions with the physician during the family meeting, respecting his or her professional suggestions or ideas, offering unbiased professional management plans, reminding all involved about the potential risks of unnecessary testing, and offering reassurance that the right care will be delivered to the patient are all important steps to take. I must stress that reassurance, and emphasizing standard of care for VIP patients, is the next key to success after effective communication, as in this pacemaker case.

VIP syndrome is an exigent issue and needs to be managed appropriately. Clinicians should be well-conversant with handling this issue in order to not compromise care by simply bending the rules for VIPs. Remember, primum non nocere—first, do no harm—is always our fundamental guiding principle in our daily clinical practice. ❖

How to Cite this Article

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