Beware of the VIP Syndrome

Since 1964, a "VIP syndrome" has been recognized. It occurs when a very important person (VIP) is admitted to a health care facility and the status of that person affects decisions about medical care. After the assassination attempts on the pope and the president, a number of commentaries on this syndrome appeared in various journals. These commentaries reflected the problems inherent in the sudden, unexpected arrival of a VIP in the emergency room or inpatient treatment unit. I believe this syndrome has spread further into the various medical services. It is prevalent in tertiary referral hospitals, particularly in those serving government officials.

The syndrome manifests itself in different ways. There may be an alteration in the usual care of the patient such that the decision is made to do fewer tests, diagnostic procedures, or therapeutic maneuvers. This decision usually reflects the wish to save the VIP from pain. Frequently the decision to forego the painful procedure leads to a missed diagnosis.

On the other end of the spectrum is the decision to follow up every minuscule abnormality so as to appear to be a more complete and competent physician. Such abnormalities (eg, a transaminase level 2 U above normal) might be ignored or the test just repeated at a later date for the usual patient, but not for the VIP. Often the sequence of the workup leads unnecessarily to exactly what one would wish to avoid, namely, the procedure that causes pain (eg, liver biopsy).

Compounding these distractions from usual medical care are the many important visitors who mean well but make suggestions that are difficult to ignore. Since the visitors are often also VIPs and even superiors of the attending physician, their opinions cannot be summarily dismissed.

Rational thought will tell you that your usual medical care is correct care and that any deviation from that usual care is probably not an improvement. Experience has proven to me that deviations from standard care often result in unforeseen catastrophes. This sequence is probably responsible for the observation that the strangest things happen in hospitals to doctors' relatives and other important patients. If the decisions made about VIPs actually resulted in better care, then they would be made for all patients.

It is necessary for the attending physician to take command and lay down the law. The VIP rarely objects to the attending physician's taking command of the medical care. It is the followers of the VIP—the hospital administrators, the important family and friends, and the curious onlookers—who are made uncomfortable. The best decisions in reversing the ravages of the VIP syndrome are to take measures to ensure the privacy of the VIP, to place limits on the visitors, and to explain that the care will be identical to that given to all other patients with the same condition. There is nothing biologically different about a pope or a president, and there is no need to alter one's thinking in caring for them.

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High-Dose-Rate Endobronchial Brachytherapy in the Treatment of Bronchogenic Carcinoma

In North America, there are 165,000 new cases of bronchogenic carcinoma each year. Sixty to 80 percent of these patients have inoperable disease at presentation; another 10 to 20 percent are found to have extensive disease at thoracotomy. Up to 50 percent of patients eventually develop signs and symptoms referable to endobronchial disease, including cough, hemoptysis, dyspnea, chest pain, and postobstructive pneumonitis. External-beam irradiation is an established palliative treatment for these patients with inoperable disease. Recently, brachytherapy has become available as a therapeutic modality in this setting.

The term "brachytherapy" is derived from the