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Very Important Person Syndrome in Patients with Substance Use Disorders

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Introduction

Very Important Person (VIP) syndrome in psychiatric settings was first described by Weintraub [1] in 1964 and was associated with "therapeutic failures." Subsequently, other physicians have gone on to describe the syndrome in the medical-surgical setting [2] and emergency department (ED) [3].

VIPs may be celebrities, people with stature in the local community, benefactors to the hospital, or healthcare professionals and their family members. VIPs have also been defined as "Very Intimidating Persons" or anyone who causes the health care provider to have anxiety or tachycardia [4]. Whether intentional or unintentional, the presence of a VIP tends to disrupt standard medical practices.

Block [2] illustrated how VIP patients may have more tests ordered than typical patients in an effort to be extra thorough and avoid missing anything, or to appease the VIP or his or her family. Conversely, necessary but painful procedures may not be done for VIPs in order to spare the VIP discomfort [5]. It is believed that deviations from standard medical practice often result in substandard and often more costly medical care for the VIP patient [1,2].

To date, there has been no description of how VIP syndrome may present in the treatment of patients with substance use disorders. This article will give three brief case summaries of VIP patients with substance use disorders and how their treatment providers, who were not specialists in addiction, engaged in behaviors that could have negatively affected the care and outcome of these VIP patients. Following the case descriptions, features of VIP syndrome in substance use disorders will be described and ways to avoid it will be suggested.

Case Summaries

Case one

Alex is an Intensive Care Nurse (ICU) who presented for outpatient detoxification from alcohol. In the psychiatric ED, he stated he planned to work during detoxification, which is not recommended for any patient undergoing detoxification. He reported he was going to work the following day, so the doctor gave him a two-day supply of chlordiazepoxide. He subsequently went to work in the ICU while experiencing alcohol withdrawal and taking medication known to be sedating. When Alex presented for follow-up in the outpatient detoxification clinic after his two-day supply of medication was exhausted, he was very symptomatic, with an elevated blood pressure and pulse, tremulousness, diaphoresis, and anxiety. He was instructed that he needed to take the remainder of the detoxification period off for the safety of his patients and himself.

Case two

Beth, a nurse and faculty member at a local university, presented to the psychiatric ED for depression and anxiety. When she was triaged on a weekday morning, her breath alcohol level was positive. During the course of the evaluation in the ED, she reported her drinking increased over the past three months to a bottle of wine per day and she was also taking 1-2 mg of clonazepam daily. Prior to her referral to the outpatient detoxification program, the resident psychiatrist seeing the patient called the detox program to ask about disposition planning after Beth completed detoxification. The resident did not think the patient would be appropriate for the dual diagnosis Intensive Outpatient Program (IOP) because she did not believe this patient "fit in with that population." The following day, the patient presented to the detoxification program and a thorough substance history was performed. The ED team reported that aftercare treatment was arranged for Beth in the mood and anxiety IOP. After the director of the mood and anxiety IOP was given Beth's detailed substance history, she no longer believed Beth could be adequately treated in her program. Beth was then referred to a dual diagnosis IOP upon completion of detoxification.

Case three

Lee is a family member of a prominent faculty member at a local university. He was prescribed opioids for several years by a physician in the community. The opioids were not being used for the treatment of pain. Lee presented to another physician and expressed a desire to stop using opioids. The physician determined Lee has an opioid use disorder. Lee maintained that he cannot take buprenorphine, refused a referral to a methadone program, and refused referral to a detoxification program. Therefore, Lee was given a taper of the opioid medications over several months. On one occasion, Lee reported he had an argument with his girlfriend about the pills and he became so upset that he "threw out" some of the pain medications. He subsequently presented to his physician, relayed these events, and asked for an early refill. Lee was given an early refill of the opioids. The physician also called Lee's insurance company to obtain an override for the early refill so Lee would not have to pay cash for the medication.

Features of VIP Syndrome and Ways to avoid it

The VIP patient is not asked a full substance use history or asked about high risk behaviors such as injection drug use and unprotected sex

Providers are often hesitant to ask VIP patients a full substance use history or sexual behavior history, possibly due to fear of insulting the VIP patient.

Beth the nurse was not asked a thorough substance use history. Based on the report from the ED, it appeared Beth provided limited

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drinking history and was not asked for any more detail. Of note, the first day Beth came to the outpatient detox clinic, the psychiatric resident was able to get substantially more information about Beth's drinking history. However, the resident did not ask questions about taking alcohol to work, nor did she ask Beth about illicit substance use, even though she asked all other patients about this. Upon reflection, the resident reported she felt that she would insult Beth by asking those questions.

All patients should be asked a thorough substance use history. If this is not done, substances used, the length of time a substance is used, and the potential for withdrawal could be overlooked. As a result, treatment could be compromised. If the VIP is in an inpatient setting, withdrawal syndromes may go unrecognized and untreated. In the case of alcohol or benzodiazepine withdrawal, this could have severe consequences, such as withdrawal seizures or delirium tremens. If the patient is in an outpatient setting, the patient may continue to use substances to avoid going into withdrawal. Substance use cannot be a focus of treatment if the treatment provider is not aware of it. Additionally, all patients need to be asked about high risk behaviors. Patients who engage in high risk behaviors are at risk for hepatitis B and C, HIV, and sexually transmitted infections. If patients are not asked about such behaviors, they will not receive appropriate testing, potentially losing the benefits of early treatment and putting them at risk for infecting others.

VIP patients are given special referrals to spare them from participating in addiction treatment

VIPs are spared from being referred to addiction treatment because it is believed they "wouldn't fit in." Special time is taken to make referrals to get VIPs into treatment elsewhere, even though this treatment may not be appropriate.

In the case of Beth, the psychiatric team in the ED spent more time on disposition planning for Beth due to her VIP status than for typical patients. Disposition planning for non-VIP patients typically ends with the referral to outpatient detoxification. The ED team involved in Beth's care assumed the usual process of aftercare planning at the outpatient detoxification program would not be adequate or appropriate for a VIP patient.

Patients with substance use disorders should be referred to addiction treatment programs or dual diagnosis programs. Research has consistently shown that integrating treatment for co-occurring disorders is more successful than parallel or sequential treatment for either condition [6]. Though there is more stigma in society against people with substance use disorders than other psychiatric disorders, this should not influence the referral process [7]. There are programs for healthcare professionals with substance use disorders and co-occurring disorders, and many other types of programs in the community that may serve patients with varying backgrounds. Addiction specialists are aware of these resources and will be able to make these referrals.

VIP patients are given "courtesies" not afforded to other patients

These courtesies may be due to a VIP trying to dictate his or her own care or actively engaging in addictive behaviors. These courtesies are deviations from standard medical practice. For example, the VIP may be given extra medications due to VIP obligations or early refills for "lost" or "stolen" prescriptions. Professional courtesies, when they involve a deviation from standard care, should be avoided because they put the patient at risk for a poor outcome and put the physician at risk for a lawsuit and loss of his or her license and DEA registration.

Alex, the ICU nurse, was given the "professional courtesy" of two days' worth of detox medication so he could work during alcohol detoxification. This deviation from standard practice put Alex and the patients he was treating in the ICU at risk. Alex should not have gone to work while physically ill and taking a medication with sedating properties that had the potential to impair his concentration and coordination. His condition could have led to accidents and errors while caring for patients.

Lee, who was taking opioids not for the treatment of pain, was given the professional courtesy of detoxification using the opioids to which he was addicted, rather than using FDA-approved medications for the treatment of opioid dependence and/or withdrawal (e.g., buprenorphine and methadone). This is a violation of the Controlled Substances Act and the physician could lose his or her medical license and DEA registration. Furthermore, when Lee ran out of the prescribed opioids early and had an explanation that might suggest misuse or diversion of the medications, his physician provided him with an early refill and called his insurance company to get an override so Lee would not have to pay for the medications himself. This physician's behaviors may result in the expectation for continued early refills, or far worse outcomes, such as accidental overdose and death of the VIP.

Conclusion

There appears to be a VIP syndrome affecting VIPs presenting for treatment of substance use disorders. Core features revolve around fear of embarrassing the VIP, fear of stigmatizing the VIP by referring him or her to addiction treatment, and allowing the VIP to dictate his or her care. Patients with addiction are susceptible to poor outcomes if a thorough history is not obtained, referrals to proper treatment are not made, and the normal standard of care is not followed.

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