As the saying goes, if you are able to keep your wits about you while all others are losing theirs … then maybe you don’t really understand what is going on. But keeping one’s wits under trying circumstances is precisely what medical education and experience should equip one to do.

Outside of psychiatry, the necessity of training to respond appropriately in overtly high-pressure situations is well-recognized in specialties where emergent circumstances such as cardiac arrest, multitrauma cases, etc., are common. The mission is clear to all, as is the need for one person to take charge, prioritize needs, and direct the team’s efforts.

Although emergent situations are rare in psychiatric practice, there are acute situations such as when a patient is imminently suicidal or potentially assaultive. These circumstances arise often enough that by the end of residency the fledgling psychiatrist usually is equipped to manage them competently. Even so, occasionally there are situations in which composure and clear thinking are harder to maintain. One such situation is when dealing with a patient who is, for whatever reason, somehow seen as “special;” more seems to be riding on the clinical outcome of the case.

The “special” designation may come from outside forces; for example, if the patient is famous, or rich, or powerful. When such a patient presents, one may begin to feel rather like the sparrow who wandered into a badminton game: ignorant of the rules and battered by unfamiliar forces on all sides. Hospital administrators emerge from their offices, clinical superiors demand to know what is going on, line staff become frustrated … and suddenly even simple clinical decisions are no longer simple.

Occasionally there are situations in which composure and clear thinking are harder to maintain.

When thrust into such situations, one’s psychiatric training often helps determine what the motivations of the various players are, what agendas (overt or otherwise) are being pursued, and whose interests are being advanced — thereby allowing some clarification and perhaps even control over events. I suspect, though, that more often the pressure is purely internal: the VIP patient is not a celebrity or benefactor, but perhaps a colleague or a colleague’s close relative. And in their time of need, they have turned to you.

Such situations arise rarely and unpredictably; as a result, it is easy to go astray. Perhaps it requires what Aristotle called “phronesis:” practical wisdom — knowledge gained through experience as opposed to the sort gained solely from theory. It is experience that allows one to be decisive and to act effectively when conditions are unsettled.

But an appeal to experience alone is unsatisfactory; and it is to be hoped that having practiced for years is not a requirement for successfully navigating such treacherous waters. If nothing else, that implies that the ability to handle such situations comes from past errors.

Rather, what is required is the ability to recognize and thus allow for the self-imposed pressures and doubts; balancing one’s own uncertainties with careful and reasoned clinical judgment while maintaining a composed outward appearance, and knowing that lending composure to other team members will help them perform better as well.
Explicit consideration of the issues raised by VIP patients may make it easier to deal with them. Elizabeth McIlduff Georges, MD, and colleagues (including myself) frame the problem by exploring the nature of the VIP patient and the kinds of psychological responses that such patients can trigger in the clinician, as well as how such patients can disrupt the system of care (see page 15). Means by which such situations can be recognized and addressed, and ways residents can be trained to respond when faced with the VIP patient are also explored.

Michael Marcangelo, MD, addresses the additional challenges faced by the consultation-liaison psychiatrist (see page 20). In the role of consultant, the psychiatrist is often called upon to assist in the care of patients who may be less than ecstatic over the prospect of dealing with a mental health professional. When the unwilling patient is a VIP, the obstacles become even greater, and can undermine the efforts of the treatment team in a variety of ways.

The practical consequences of dealing with the VIP patient, and how he or she can be managed safely on the inpatient psychiatric unit, is explored by Megan B. Schabbing, MD, (see page 25), who also examines how throughout history, special treatment for VIP patients has ended in failure.

The VIP patient usually receives additional attention and care, often without question. When questions are raised, efforts to justify this differential treatment are often made. Jennifer K. Walter, MD, PhD, a pediatrician and bioethicist, reviews these arguments and explores the ethical concerns such disparate handling raises (see page 30).

Treating the VIP patient also raises a number of medicolegal issues and can lead to unusual and even counterintuitive risks. I address these concerns in an article on page 33.

In “Resident’s Viewpoint,” (see page 38), Dr. Georges provides a vivid firsthand account of having been thrust into the midst of a high-pressure VIP situation.

I hope the articles in this issue are of use to you and your practice.

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about the guest editor

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