How could a reputation for excellence or striving to provide superlative care lead to a medicolegal risk? On its face, the idea seems ludicrous — but in fact, treating those who need (or demand) special handling may entail unique hazards to the practitioner and to the hospital.

Groves has suggested a useful tripartite typology of such special patients: celebrities, VIPs and potentates, ie, the well-known, the well-connected, and the very well-off. To this list might be added a fourth category — those who, for reasons of their own, may simply demand special privilege. Caring for individuals in any of these categories can lead to unexpected and even counterintuitive sorts of risk.

RISKS TO CONFIDENTIALITY

Celebrities, however defined (to be famous does not necessarily mean to be held in positive regard), create several challenges to optimal care. First, of course, is the significant risk to confidentiality that the individual faces.

Attention to patient privacy has been enhanced since the passage of the Health Insurance Portability and Accountability Act (HIPAA) of 1996: “Protected health information” (PHI) is considered to be any information relating to physical or mental health conditions (past, present or future), information regarding provision of health care, or information as to payment for health care whether past, present or future that can be linked to an individual. Anything that could be used to link such PHI to a given individual must, by law, be treated with special care so as to avoid the disclosure of such information without the patient’s permission.

One of the goals of HIPAA was to protect the privacy of all patients in the
digital age, when transfer of records is far easier than ever before. But, at least for those whose lives are material for gossip and speculation on the national stage, electronic medical records may have worsened the risk of breach of confidentiality. In 2008, for example, the Los Angeles Times reported that nearly 70 hospital employees of the UCLA Health System, including physicians, had been accused of inappropriately accessing medical records of several well-known patients; of particular note (as this article is being written the scandal involving “hacking” and payment to sources by Rupert Murdoch’s News of the World continues to evolve), one of the employees was accused of selling this information to news agencies.

Ultimately, after an investigation by the Department of Health and Human Services’ Office for Civil Rights, the UCLA Health System agreed to an $865,500 settlement for violations of HIPAA privacy and security rules. In particular, that agreement noted that “numerous” employees had improperly accessed medical records; that employees were either not properly sanctioned for this behavior or the sanctions were not properly documented; that the institutions involved did not provide (or at least document) proper training of employees regarding the relevant HIPAA rules; and that the institutions had not implemented sufficient electronic security measures to prevent unauthorized access to records.

Privacy as a ‘Core Value’

The risk to privacy is not restricted to celebrities, of course; but it is likely that the temptation of unauthorized access to records increases with the fame (or notoriety) of the patient. The organization, therefore, is at risk to the extent that electronic privacy can be easily breached or infractions ignored.

One obvious solution is to educate employees that privacy is an institutional “core value” and violations will be strictly dealt with — and that an effective audit system to identify violations is in place. (It is perhaps worth noting here that part of the agreement cited lapses not only in security but also in the facilities’ documentation of appropriate education and sanctions.) But risks to confidentiality are not restricted to the electronic medical record. Walter has noted that the institution owes a duty of maintaining the confidentiality of the celebrity, just as it does to other patient, but that carrying out this duty may require differential effort: registering the patient under a pseudonym, taking extra precautions when transporting him or her within the hospital, providing some services in the room that might not generally be provided elsewhere, and the like.

With that ethical responsibility, obviously, comes concomitant medico-legal exposure if it is inappropriately breached. And, of course, it is important for the institution to educate staff of the dangers of talking about specific patients (celebrities or not) where others who are not members of the treatment team may overhear — in elevators, the cafeteria, and so forth.

In the case of celebrities, concern for confidentiality might extend to another group: Other patients who might recognize a famous face. It is difficult to think of a strategy that is likely to work in all cases. On a general medical unit, keeping the patient’s door shut may be all that is necessary, but in other situations (for example on an inpatient psychiatric or addiction treatment unit where group treatment is integral to the milieu), this may not suffice.

Stressing the duty of all participants to maintain the confidentiality of the group process may be all that can reasonably be done, and so, in some cases, the expected benefits of such participation may have to be carefully weighed against the potential harm that disclosure of highly personal information might cause. Although it can be cogently argued that this risk-benefit assessment is and should be done in every case of group treatment, the stakes may well be higher for those in the public eye.

INTERACTIONS WITH MEDIA

The physician providing care to the celebrity can briefly become a “talking head” for the news media. Such attention can provide a valuable service by educating the general public about a specific illness, its prevalence, presentation, and treatment.

One can think of numerous conditions from amyotrophic lateral sclerosis to hepatitis C whose profiles (and concomitant funding for research and treatment) have risen once they have become associated with a celebrity; certainly since Betty Ford, there has been no paucity of the rich and famous who have admitted to addictions of one sort or another and it is tempting to believe that addictive illness has been correspondingly (if hardly completely) destigmatized as a result.

In the case of other severe mental illnesses, however, the situation may be a bit different because of the remaining stigma attached to many such diseases. This concern has been addressed in Section 4 of the American Psychiatric Association’s code of ethics:

"11. It is ethical to present a patient or former patient to a public gathering or to the news media only if the patient is fully informed of enduring loss of confidentiality, is competent, and consents in writing without coercion."

It might be noted that “competency” (a legal construct) in this setting might be read as more or less equivalent to the clinical construct of “capacity.” However, general “competency” is presumed in adults unless there is some basis to suspect otherwise; if so, the individual’s competency sta-
tus to perform certain acts (eg, stand trial, enter contracts, execute a will, etc) may be determined judicially, although, of course, a clinical evaluation often provides the fact base upon which such a determination is based.

“Capacity,” by contrast, might be better conceptualized as a sliding scale incorporating both cognitive and emotional components. That is, clinical judgment as to the individual’s understanding of the facts relevant to the decision must be combined with an assessment of how they are being weighed in this specific case, and how the decision comports with the individual’s long-held goals and values. Rather than being an all-or-none determination, decisional capacity is better seen as having varying thresholds depending on the nature and consequences of the choice at hand.

Because of concern over subtle impairment in the patient’s capacity to decide whether or not to share sensitive information (eg, about one’s mental illness) publicly, particularly early in treatment of an acute episode, a decision to “go public” would not be one to be made lightly. There might be significant cost to the patient’s career or reputation. Failure to carefully weigh and repeatedly discuss with the patient the consequences of disclosure might result in a subsequent claim that the treating physician failed to adequately keep the patient’s inner circle quiet.

Another reason for caution might be helping the patient realize that, while the glare of publicity can have other consequences as well. While it can be tempting to use the news media as a vehicle to educate the public about mental illness (and doing so is hardly unethical), commenting specifically about the psychiatric status of a figure in the news is improper. According to section 7 of the APA’s code of ethics (often referred to as the “Goldwater Rule”):

**The stakes may well be higher for those in the public eye.**

“3. On occasion psychiatrists are asked for an opinion about an individual who is in the light of public attention or who has disclosed information about himself/herself through public media. In such circumstances, a psychiatrist may share with the public his or her expertise about psychiatric issues in general. However, it is unethical for a psychiatrist to offer a professional opinion unless he or she has conducted an examination and has been granted proper authorization for such a statement.”

**RISKS TO THE PATIENT**

In malpractice actions, two of the components that are generally not difficult to establish are establishment of a duty to the patient, and harm to the patient. Determination of the applicable standard of care, how it might have been breached, and how that breach contributed to the damages may be more challenging. It seems odd to think that harm could be alleged based on trying to exceed the standard, but it can occur.

**Physicians and ‘Self-Doubt’**

As the treating clinician, one is always vulnerable to self-doubt. Within limits, this is not a bad thing; better to reflect on treatment decisions and critique them, identifying errors and deficiencies in knowledge base that may be corrected than to unthinkingly routinize care. But too much reflection can lead to paralysis of decision, particularly when the stakes are perceived to be higher.

Certain patients may be seen as special for a variety of reasons other than notoriety, and thus a variety of psychological factors may come into play. Particularly when the patient is a physician or a colleague’s close relative, there may be a strong temptation to provide extra services or more attentive care as a way of demonstrating that the colleague’s faith in choosing the treating psychiatrist was not unjustified.

On services other than psychiatry, there is perhaps a greater risk of overtreatment, eg, the patient whose postoperative pain is so vigorously addressed that she has a respiratory arrest, but it should be kept in mind that too vigorous treatment of medical conditions may also occur on the psychiatric unit, with the consequent risk of iatrogenic complications.

In the case of patients who have been substantial donors to the institution (or who might become such donors), special treatment may be requested by the patient or by institutional leadership, with the implicit message that financial consequences may ensue — good or bad, depending on the willingness of the attending physician to “play ball.” This pressure may come in the form of insistence that multiple consultants become involved in the case, with a corresponding increase in risk of “groupthink” (the phenomenon in which individuals seek to minimize conflict by reaching consensus).

Instead of choosing between two treatment choices, for each of which there are data on probability of good response and for which risks are well known, in clinical practice, “groupthink” may play out by the treatment
team opting for a plan that melds features of each of the alternatives — but which has no empirical basis itself.

It may be that psychiatric treatment is more vulnerable to such phenomena simply because so many treatment decisions must be based primarily on clinical judgment. Examples of this include when suicide precautions should be discontinued, or whether the patient is stable enough for discharge. There is little that is truly objective upon which decisions such as these and many others can be based.

With any patient, there may be a temptation to acquiesce to his or her requests for a relaxation of scrutiny and control; one of the more difficult tasks of residency training is to equip the psychiatrist with the judgment and fortitude to deny such requests when necessitated by clinical circumstances.

**Breaches to ‘Standard of Care’**

Thus the issue of standard of care, and breach thereof: It should be recalled that, while the standard is often determined by expert testimony, it need not be — it may be established by the institution’s own policies and procedures.

There may be valid clinical reasons to deviate from these, but if so, the rationale should be carefully thought out and clearly documented. In the case of the powerful patient who demands such deviation, it is well to consider which procedures might be undermined and what potential dangers might be associated with such a departure — for example, the potentially suicidal patient who resists transfer to a psychiatric unit out of fear of stigma (or out of lack of insight into his illness) or who, once on the psychiatric inpatient unit, resists 1:1 observation because of the inherent invasion of privacy.

Once on the unit, such individuals may legitimately be concerned for their privacy, and deviation from the usual unit expectations regarding group attendance and the like may well be justified. On the other hand, for some conditions behavioral activation can be an important part of treatment and can substantially lessen the period during which the patient is most at risk for self-harm.

Another way in which the standard of care might be breached through deferring too readily to the wishes of the powerful or entitled patient is by insufficient history-taking, avoiding confrontation rather than probing for information which, while possibly painful or embarrassing, might be of great clinical importance. Such omission can lead to erroneous diagnosis and, hence, inadequate or inappropriate treatment. In the case of physicians who have been psychiatrically hospitalized, drug or alcohol addiction is frequently missed, even though the association between addiction and completed suicide is well-established and there is evidence for higher risk of suicide among physicians.9-12 Another possible source of discomfort is the realization that if the physician-patient’s illness has caused significant professional impairment, a conflict between the duty to maintain patient confidentiality and the responsibility to report such impairment to licensing bodies may arise.

How can these risks be, if not averted, at least minimized? First, of course, one should assure that a proper evaluation has been done and, based on that evaluation, treatments offered are, to the extent possible, solidly based on sound biomedical research. As reliance on clinical judgment increases, the treating psychiatrist should feel comfortable that any deviation from usual and customary care is justified by the patient’s unique situation and not by external pressures. If there is concern that his or her judgment might be undermined, consultation with an experienced colleague can be invaluable. As a protection against “groupthink,” it should be clear to all whom among them is the “captain of the ship”— the one with ultimate clinical responsibility. In a situation in which “splitting” — patient versus staff, administration versus psychiatrist, publicist versus hospital, or any other of the myriad possible combinations that can arise — is practically inevitable, the usual precautionary actions and countermeasures should be employed. This includes clear communication between all parties, explicit delineation of responsibilities, and frequent updates.

**BOUNDARY ISSUES**

Another concern in dealing with the famous and powerful is the potential for deviation from the usual doctor-patient relationship.

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Another concern in dealing with the famous and powerful is the potential for deviation from the usual doctor-patient relationship. (see Georges and colleagues, page 15). This can take several forms. The treating psychiatrist may relax the usual professional distance from the patient because of the allure of celebrity or money and become neither precisely a professional nor a friend — and not effective in either role. According to section 1 of the APA’s ethical code:7

“1. A psychiatrist shall not gratify his or her own needs by exploiting the patient. The psychiatrist shall be ever vigilant about the impact that his or her conduct has upon the boundaries of the doctor–patient relationship, and thus upon the well-being of the patient. These requirements become particularly important because of the essentially private, highly personal, and sometimes intensely emotional nature of the relationship established with the psychiatrist.”

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Although the issue of “boundary violations” continues to be debated, it should be noted that malpractice suits and adverse licensure actions have been successfully brought on the theory that such violations are by their very nature harmful.13,14 The APA’s ethical code also addresses a related problem, improper use of private information. According to section 2.7, “The psychiatrist should diligently guard against exploiting information furnished by the patient and should not use the unique position of power afforded him/her by the psychotherapeutic situation to influence the patient in any way not directly relevant to the treatment goals.”

Cases have been brought against psychiatrists for a variety of such boundary problems, including “insider trading,” alleging that information disclosed during treatment was used by the psychiatrist for investment purposes, and undue influence in bequeathing money.15 It should be obvious that the best way to evade the dangers of boundary violation is to keep one’s role as a treater and advocate for the patient’s best medical interest separate from personal desires for connections with wealth and fame.

CONCLUSION

With the clinical challenges presented by the “VIP patient” come corresponding medicolegal risks. Some of these derive from heightened threats to patient confidentiality, both from inside and from outside of the institution.

Others come from the clinician’s own vulnerabilities — to real-life pressures exerted by patients, families, administrators, lawyers, publicists, or others, and to psychological factors which, though they may differ in emphasis, are to some extent common to all professionals. Even in everyday practice — every patient, after all, is “very important” — the stakes can be high, the decision-making complex, and the pressures (internal and external to the clinician) enormous.

It might cogently be argued that psychiatrists should be aware of and skilled in identifying and safeguarding against these threats to optimal care and so treating the VIP patient should, in the end, provide no greater challenge than caring for anyone else.

In practice, however, by virtue of their power, prestige or prominence, certain patients can become a nexus for factors that can differentially threaten or negate appropriate treatment efforts.

REFERENCES