

## The VIPoma

Robert C. McIntyre, Jr., MD, Aurora, Colorado

It has been an honor and privilege to serve as the president of the Western Trauma Association (WTA) for the past 2 years. The topic I have chosen for today is the VIPoma. Right after assuming the presidency, I reviewed the mission statement. The WTA is “committed to the improvement of trauma care through research, education, sharing of clinical experiences . . . The goals of the Association are . . . the emotional growth attained through camaraderie and interaction with family and friends” (<https://www.westerntrauma.org/>). The two critical parts of this statement are “improvement of trauma care through research, education, and sharing of clinical experiences” and the focus on “family and friends.” I found my way to the WTA through mentorship of Gene Moore, MD. The first paper I presented at a national meeting was on pediatric pelvic fractures.<sup>1</sup> In the next few years, I was lucky to get papers on the program working with Gene and Fred Moore, MD, on Acute Respiratory Distress Syndrome.<sup>2,3</sup> I have immense gratitude to Fred Moore, MD, who got me actively involved in the WTA when he asked me to lead the *Critical Decisions in Trauma* committee to develop algorithms intended to aid the clinician at the point of care.<sup>4</sup> Fred tapped me since I had taken over as editor of *Surgical Decision Making*.<sup>5</sup> In total, there have now been 31 published algorithms from the WTA.

Family involvement has been critically important to the WTA. In 2006, the Trauma Family Tree from Indiana University was constructed using social networking analysis. This led me to think about my own WTA family tree in Denver (Fig. 1). We have had numerous abstract presentations centered on the disease and injury management of our own families. This brings me back to the VIP syndrome, or the very important person syndrome, first described in 1964.<sup>6</sup> In 1996, a 62-year-old male division chief in another department was transferred after crashing a bike on a steep hill. The patient was stable and had multiple rib fractures, pelvis fracture, and spleen injury. I was nervous about taking care of this senior division chief as a young faculty member. Over the years, I have found it to be a privilege and humbling experience to give medical care to physicians and their family members. Although extra time and effort are required, acting as a physician's physician has been a gratifying and worthwhile experience. This experience has allowed me to develop my top

10 suggestions for the care of one of our own, that is, a physician-patient or relative of a physician.

1. Do not accept such patients if you are likely to feel an excessive degree of anxiety. You may feel greater concern than usual with nonmedical patients since your skill will receive greater scrutiny. This often leads to indecisive actions. You may feel the need to alter the usual care of the patient such that you may do fewer tests, diagnostic procedures, or therapeutic maneuvers. This decision usually reflects the wish to save the VIP from pain. Frequently, this decision can lead to a missed diagnosis or delays in care. On the other end of the spectrum is the decision to follow up every minuscule abnormality to appear to be a more complete and competent physician. I have heard many times from people more than happy to give me advice about how to take care of my physician-patient: “you do not want to do that because the patient is Dr. Jones.” Back to the case, after admission, the hemoglobin level dropped, resulting in transfusion of 2 U of packed red blood cells. The hemoglobin fell again, and 2 U more of packed red blood cells was given. Finally, splenectomy was done on day 3. The patient slowly recovered and had a hospital length of stay of 14 days. This is not exactly what I would now call a good outcome. Did I mention that one of the problems of taking care of the physician-patient is indecisive actions?
2. Perform the history and physical examination as thoroughly as for any other patient. By doing so, you establish trust with the patient. I purposefully do not avoid the personal medically relevant questions for fear of awkwardness. Furthermore, be sure to take the history directly from the patient and not the doctor-relative. Patient 2 was a 50-year-old man traveling in Italy. He developed abdominal pain and diarrhea. The patient's brother was an Emergency Medicine Professor who reported his brother was self-medicating with Flagyl. Upon return to the United States, he presented to the emergency department (ED), and computed tomography (CT) scan suggested perforated appendicitis. The patient underwent laparoscopic appendectomy and washout of peritonitis followed by intravenous antibiotics. The patient improved, started a diet, and had bowel movements spending 10 days in the hospital. He returned 7 days later with increasing abdominal pain and leukocytosis. A second CT scan showed diverticulitis. The patient underwent sigmoid colectomy with anastomosis and diverting loop ileostomy. The appendectomy pathology suggested an extrinsic process but no true appendicitis. Pathology on the second operation was consistent with sigmoid diverticulitis.
3. Deal openly with the patient's anxiety and allay it as soon as possible. Physician-patients have as much anxiety as all

Submitted: March 3, 2022, Revised: March 26, 2022, Accepted: March 30, 2022, Published online: April 8, 2022.

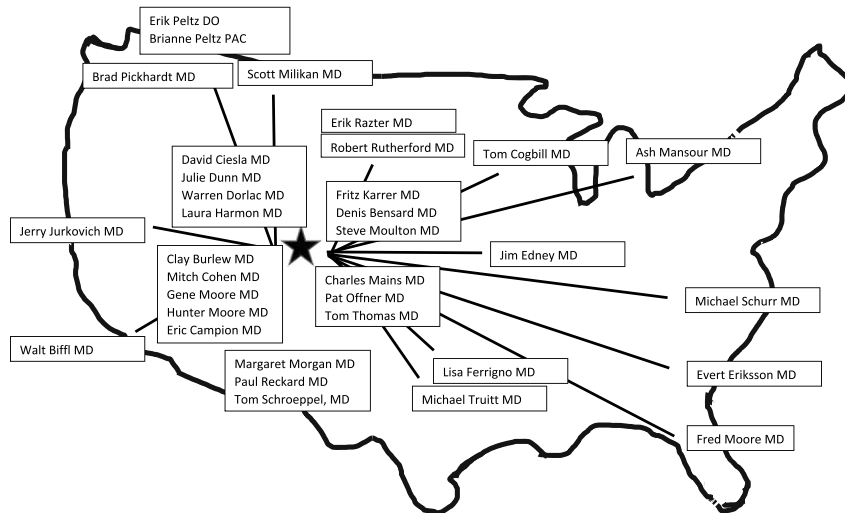
From the Division of GI, Trauma and Endocrine Surgery, Department of Surgery, University of Colorado Hospital, University of Colorado School of Medicine, Aurora, Colorado.

This work was presented at the 51st Annual Meeting of the Western Trauma Association on February 22, 2022, Big Sky, MT.

Address for reprints: Robert C. McIntyre Jr., MD, Division of GI, Trauma and Endocrine Surgery, Department of Surgery, University of Colorado School of Medicine, 12631 E 17th Ave, Box C313, Aurora, CO 80045; email: robert.mcintyre@cuanschutz.edu.

DOI: 10.1097/TA.0000000000003643

*J Trauma Acute Care Surg*  
Volume 93, Number 5



**Figure 1.** The Denver family tree of the WTA.

other patients. I actively ask for and discuss the physician-patient's own diagnosis if they have one. Some of the best advice about giving news to patients and families comes from Dr. Jurkovich.<sup>7</sup> He and his colleagues surveyed surviving family members of patients who died in the ED or trauma intensive care unit (ICU) at Harborview. The elements that ranked highest by the family were attitude, clarity of message, privacy, ability to answer questions, sympathy, and time allotted for asking questions. At the bottom of the list was the rank or seniority of the news giver, ability for follow-up contact, and attire of the news giver. I use these survey results in how I approach discussion with the physician-patient and all other patients.

4. Clarify the patient-physician relationship as early as possible. I always assure the patient that they will be treated in the most appropriate manner. I ensure them that our physician-patient relationship will remain confidential. I relay information to them as soon as possible. I listen carefully to their concerns as promptly as possible. Most importantly, I empower the physician-patient with the same degree of decision-making autonomy as I would with any other patient. The most important aspect of patient autonomy is the consent process. In the typical consent scenario, we present patients with details of a procedure with a discussion of risk, benefits, and alternatives. Two alternatives are often presented to patients in as dispassionate a manner as possible, asking the patient which of the alternatives they prefer. This informative approach forcing the patient to choose when they are not expert in the area does not serve the patient well. I think it is our obligation to present a clear preference without a paternalistic approach.

Shared decision making is a collaborative process that allows patients and their providers to make a health care decision together. It uses best clinical evidence available and the patient's values and preferences. The shared decision-making model is well designed for elective surgical procedures. However, it is not the most useful technique in an acute emergent and invasive environment. Furthermore, it is also not always the best model in the ICU.

An alternative approach promulgated by Gretchen Schwarze, MD, is the best-case/worst-case scenario.<sup>8,9</sup> This tool relies on storytelling rather than citing a lot of statistics. A common ICU situation is that we give daily updates to the family, discussing the problems with laboratory and imaging results. This technique leaves them unable to process all of this information. Imagine you have an older patient with significant comorbidity critically ill in the ICU after a major operation. In the best-case scenario, this patient will need time in the ICU and in the hospital for recovery. They may have functional deficits and need rehabilitation before they recover to return home. In the worst-case scenario, this patient develops major organ dysfunction, requires prolonged life support, and fails to return to an ability to interact with their family members. After a prolonged course, the patient may die while on life-support measures. After framing the best and worst case, we focus on what is the most likely or probable outcome. The best-case/worst-case technique relies on a good understanding of the patient's values. Asking the patient and their family how they are thinking about this information is important. If they made a decision, it is equally important to understand how they made the decision. Thus, you can make sure their values and expectations align with what you recommend and is realistic. Finally, it is our responsibility to make a recommendation.

5. Avoid overly close identification due to empathy or sympathy. While this is understandable with the physician-patient, it can inhibit necessary diagnostic testing and therapy. I recommend avoiding negotiation, which may lead to too many or too few decisions. I avoid modifying my routines to save the patient time, trouble, and pain, which may result in poor medical care. I discourage the physician-patient from self-ordering studies or ordering them for their relatives.
6. Discuss the diagnostic and treatment plan in detail to diminish anxiety. Do not take for granted or assume that the physician-patient knows as much as you do about the medical problem, particularly if it is outside his/her practice area.
7. Leave plenty of time for a clear discussion of your opinions and recommendations. Avoid citing a lot of studies and statistics

without giving a clear opinion. Offer the opportunity to obtain a second opinion, which emphasizes the patient's autonomy. A physician-patient may experience added discomfort asking for a second opinion. It is important to make sure that the physician-patient knows you would encourage and welcome a second opinion to make sure the physician-patient is totally comfortable with the proposed treatment plan. Only two things can come from a second opinion, confirmation or the opportunity to further discuss and gain clarity around options. I guard against an overly intellectual discussion with the physician-patient when reviewing results and plans with their family members.

An additional new paradigm for the application of quantitative risk assessment uses objective risk and outcomes data in informed consent. One example is the Surgical Risk Preoperative Assessment System (SURPAS) (Fig. 2).<sup>10-12</sup> This is an individualized, preoperative risk assessment using only eight variables to accurately predict the risk of 30-day complications. The SURPAS predicts need for ICU admission, unplanned return to the operating room, discharge destination, and unplanned readmission.<sup>13-15</sup> It was developed using the National Surgery Quality Improvement Program database to develop a parsimonious model and reduce the burden of data collection. This model had little to no decrement in the predictive discrimination or calibration when compared with the National Surgery Quality Improvement Program risk calculator using 28 data elements (<https://riskcalculator.facs.org/RiskCalculator/>). Using both quantitative and qualitative methodology, the SURPAS group developed a tool to effectively convey risk information to patients using the pictograph method.<sup>16,17</sup> In one study designed to determine the effects of using SURPAS compared with surgeons' "usual" consent process, 82% of SURPAS patients were "very satisfied" with risk discussion versus 16% of usual consent patients. Of those who used SURPAS, 75.3% reported that the risk discussion made them "more comfortable" versus only 19% of patients following the usual process. Among the SURPAS patients, 97.9% reported "enough time spent discussing risks" versus 72.0% of usual patients.<sup>18</sup>

8. Speak directly to the patient without the intermediation of the physician-relative. This often requires you spend time

alone with the patient. However, make sure that you do not tell relatives anything different from what you tell the patient.

9. Discuss issues of privacy, confidentiality, payment, and insurance early if the patient has any question about these issues. Medical people know that we frequently discuss patients in the hallways. Assure the patient and the family honestly that this will not happen. This is an opportunity to ask the physician-patient if there are concerns about being treated at this location or by members of your team. Medical billing is not something that many health care professionals look at often. It is a frequent cause of concern and anxiety.

I recently had a family member who was admitted and had emergency surgery. She was readmitted a first time and then second time. My insurance company denied the first readmission. I appealed this decision, and again, the second admission was denied. Following the insurer's rules, I filed a second appeal, which was denied. I hired an attorney, and eventually, the denial of the second admission was overturned. As an insider, I understand and know the system. Imagine what this is like for your patients who have no idea how to navigate this difficulty. When we are asked to help patients with this problem, it is often on top of an incredibly busy schedule and is exceedingly unpleasant task. However, extreme empathy for our patient extends beyond the compassion we display to them during their medical care to helping them deal with the insurance industrial complex.

10. Professional courtesy should mean that patients receive clear instructions, speedy appointments, and a rapid response to their inquiries, not only from us but from our staff. Awareness that patienthood is the antithesis of doctorhood and that some physicians view sickness as a sign of weakness should encourage treating physicians to be supportive, protective of the dignity and independence of the patient, and always hopeful. I believe that avoidance of the VIP syndrome is paramount.

Some health care leaders speculate that the presence of a VIP may be disruptive to the care of non-VIP patients. Others have cautioned physicians about the potential dangers to the VIP themselves. Investigators from Harvard and University of

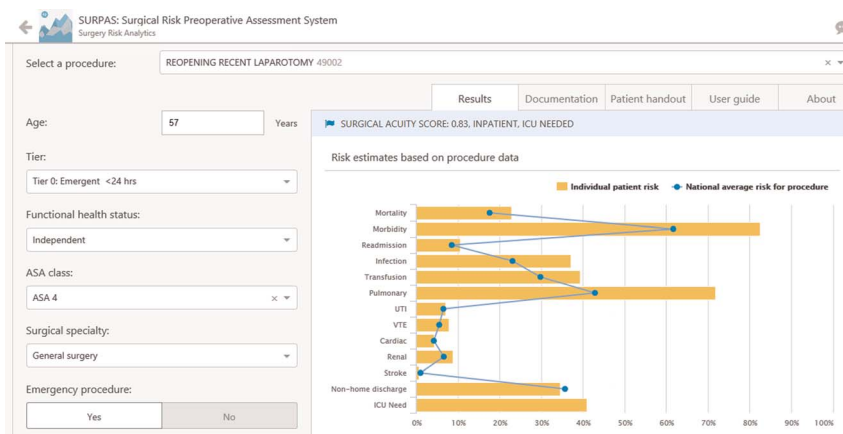


Figure 2. Surgical Risk Preoperative Assessment System (<https://surpas.agilemd.com/>).

California San Francisco used a multisite survey of hospitalists to assess viewpoints and behaviors regarding VIP services.<sup>19</sup> Seventeen percent thought that VIP care was worse, 78% thought it was the same, and only 6% thought the care was better. Sixty-three percent of physicians felt pressured by the patient or the family to do unnecessary tests or treatments, and 36% felt pressured by other hospital employees to do more. Most significantly, more than half of the physicians felt that they were likely to comply with these requests for unnecessary tests or treatment.<sup>19</sup>

Patient satisfaction or experience is a quality metric and is even tied to physician compensation. Previous studies suggest a tenuous link between satisfaction and outcomes. Patients often request discretionary services of little benefit, and physicians feel pressure to acquiesce to these requests, fearful that this would affect patient satisfaction scores. Investigators used the Medical Expenditure Panel Survey to assess the relationship between patient satisfaction, expenditures, and mortality in a nationally representative sample.<sup>20</sup> The highest patient satisfaction quartile relative to the lowest quartile had lower odds of ED visit, higher odds of inpatient admission, 8.8% greater total expenditures, and, most importantly, a higher adjusted mortality rate.<sup>20</sup> Thus, overemphasis on patient satisfaction could have unintended adverse effects on health care utilization, expense, and patient outcome.

In 1993, a 50-year-old department chairman was transferred from an outside hospital with abdominal pain. The history was that the patient had a 1-week viral syndrome and now presented with a very distended abdomen without rebound tenderness. A CT scan showed portal vein thrombosis. In 1993, a very new and radical treatment approach was undertaken with interventional radiology catheterizing the portal vein and infusing urokinase. For 2 days, the patient was repeatedly taken to interventional radiology and eventually heparinized. He underwent exploratory laparotomy with small bowel resection for necrotic bowel. He was left in discontinuity, and his abdomen remained open. Eventually, a jejunostomy and distal fistula were brought out, and the abdomen was closed. He spent 45 days in the hospital on Total Parenteral Nutrition and eventually was converted to warfarin. I took down his stomas at 3 months. Two years later, he had an incisional hernia, and I did a repair with mesh. Twenty-three years later, this patient died of metastatic renal cell cancer. On the anniversary of his hospital admission, this patient sent me a thank you card every year including the year that he passed away.

I learned a tremendous amount from these patients over the course of my career, but the most important lesson that these patients taught me is that “it is not simply enough that we care for our patients, we must care about our patients.” You may be familiar with this quotation because it comes from Dr. Jurkovich’s *Paint the Ceiling Lecture* in 1997 at the WTA.<sup>21</sup>

At the midpoint of my career, I had the opportunity to take care of a Professor Emeritus in another department for a couple of different surgical diseases over a few year period of time. After we had concluded at a follow-up visit, he reached into his briefcase and pulled out a reprint. He scribbled a note and signed the reprint handing it to me. I saw that the title of his viewpoint article was “Doctoring Doctors and Their Families.”<sup>22</sup> With trepidation, I asked him if I had done OK. He remarked that I had learned a great deal over the course of our relationship. It was

at this point that I realized that this Professor Emeritus had been one of my greatest mentors.

What lessons can I conclude with about the care of the physician-patient or physician-relative? Your usual medical care is the correct care. Deviation from that usual care is probably not an improvement. Experience has proven that deviations from standard care often result in unforeseen catastrophes. This sequence is likely the explanation for the fact that the strangest things happen to doctors, their relatives, and other VIPs. If the decisions made about VIPs resulted in better care, they would be made for all patients. In the end, there is nothing biologically different about a doctor, the CEO of the hospital, or a president, and there is no need to alter thinking in caring for them. Ultimately, the most important lesson of all is that all patients are VIPs. We must remember that “the treatment of a disease may be entirely impersonal; the care of a patient must be completely personal.”<sup>23</sup> Most important of all, there is no greater reward than to not count hours, not work 9 to 5, not watch the clock when you are still working at midnight or 3 AM and to be totally engaged in our mission. It is passion for this mission that is the greatest prevention of physician burnout.

#### DISCLOSURE

The author declares no conflict of interest.

#### REFERENCES

- McIntyre RC Jr, Bensard DD, Moore EE, Chambers J, Moore FA. Pelvic fracture geometry predicts risk of life-threatening hemorrhage in children. *J Trauma*. 1993;35(3):423–429.
- McIntyre RC Jr, Haenel JB, Moore FA, Read RR, Burch JM, Moore EE. Cardiopulmonary effects of permissive hypercapnia in the management of adult respiratory distress syndrome. *J Trauma*. 1994;37(3):433–438.
- McIntyre RC Jr, Moore FA, Moore EE, Piedadue F, Haenel JS, Fullerton DA. Inhaled nitric oxide variably improves oxygenation and pulmonary hypertension in patients with acute respiratory distress syndrome. *J Trauma*. 1995;39(3):418–425.
- McIntyre RC Jr, Moore FA, Davis JW, Cocanour CS, West MA, Moore EE Jr. Western Trauma Association critical decisions in trauma: foreword. *J Trauma*. 2008;65(5):1005–1006.
- McIntyre RC Jr, Schulick R, eds. *Surgical Decision Making*. 5th ed. Philadelphia, PA: Elsevier Saunders; 2004.
- Weintraub W. “The VIP syndrome”: a clinical study in hospital psychiatry. *J Nerv Ment Dis*. 1964;138(2):181–193.
- Jurkovich GJ, Pierce B, Pananen L, Rivara FP. Giving bad news: the family perspective. *J Trauma*. 2000;48(5):865–870; discussion 870–863.
- Taylor LJ, Nabozny MJ, Steffens NM, Tucholka JL, Brasel KJ, Johnson SK, et al. A framework to improve surgeon communication in high-stakes surgical decisions: best case/worst case. *JAMA Surg*. 2017;152(6):531–538.
- Zimmermann CJ, Zelenski AB, Buffington A, Baggett ND, Tucholka JL, Weis HB, et al. Best case/worst case for the trauma ICU: development and pilot testing of a communication tool for older adults with traumatic injury. *J Trauma Acute Care Surg*. 2021;91(3):542–551.
- Meguid RA, Bronsert MR, Juarez-Colunga E, Hammermeister KE, Henderson WG. Surgical Risk Preoperative Assessment System (SURPAS): I. Parsimonious, clinically meaningful groups of postoperative complications by factor analysis. *Ann Surg*. 2016;263(6):1042–1048.
- Meguid RA, Bronsert MR, Juarez-Colunga E, Hammermeister KE, Henderson WG. Surgical Risk Preoperative Assessment System (SURPAS): II. Parsimonious risk models for postoperative adverse outcomes addressing need for laboratory variables and surgeon specialty-specific models. *Ann Surg*. 2016;264(1):10–22.
- Meguid RA, Bronsert MR, Juarez-Colunga E, Hammermeister KE, Henderson WG. Surgical Risk Preoperative Assessment System (SURPAS): III. Accurate preoperative prediction of 8 adverse outcomes using 8 predictor variables. *Ann Surg*. 2016;264(1):23–31.

13. Rozeboom PD, Bronsert MR, Henderson WG, Velopulos CG, Colborn KL, Lambert-Kerzner A, et al. The preoperative risk tool SURPAS accurately predicts outcomes in emergency surgery. *Am J Surg*. 2021;222(3):643–649.
14. Rozeboom PD, Bronsert MR, Velopulos CG, Henderson WG, Colborn KL, Hammermeister KE, et al. A comparison of the new, parsimonious tool Surgical Risk Preoperative Assessment System (SURPAS) to the American College of Surgeons (ACS) risk calculator in emergency surgery. *Surgery*. 2020; 168:1152–1159.
15. Lin Y, Meguid RA, Hosokawa PW, Henderson WG, Hammermeister KE, Schulick RD, et al. An institutional analysis of unplanned return to the operating room to identify areas for quality improvement. *Am J Surg*. 2017; 214(1):1–6.
16. Hawley ST, Zikmund-Fisher B, Ubel P, Jancovic A, Lucas T, Fagerlin A. The impact of the format of graphical presentation on health-related knowledge and treatment choices. *Patient Educ Couns*. 2008;73(3):448–455.
17. Lambert-Kerzner A, Ford KL, Hammermeister KE, Henderson WG, Bronsert MR, Meguid RA. Assessment of attitudes towards future implementation of the “Surgical Risk Preoperative Assessment System” (SURPAS) tool: a pilot survey among patients, surgeons, and hospital administrators. *Patient Saf Surg*. 2018;12:12.
18. Wiesen BM, Bronsert MR, Aasen DM, Singh AB, Lambert-Kerzner A, Henderson WG, et al. Use of Surgical Risk Preoperative Assessment System (SURPAS) and patient satisfaction during informed consent for surgery. *J Am Coll Surg*. 2020;230(6):1025–1033.e1.
19. Allen-Dicker J, Auerbach A, Herzig SJ. Perceived safety and value of inpatient “very important person” services. *J Hosp Med*. 2017;12(3):177–179.
20. Fenton JJ, Jerant AF, Bertakis KD, Franks P. The cost of satisfaction: a national study of patient satisfaction, health care utilization, expenditures, and mortality. *Arch Intern Med*. 2012;172(5):405–411.
21. Jurkovich GJ. Paint the ceiling: reflections on illness. *J Trauma Acute Care Surg*. 1997;43(5):733–740.
22. Schneck SA. “Doctoring” doctors and their families. *JAMA*. 1998;280(23): 2039–2042.
23. Peabody FW. The care of the patient. *JAMA*. 2015;313(18):1868.