ISSN 0973-2063 (online) 0973-8894 (print)

Bioinformation 22(10): 6898-6902 (2026)

©Biomedical Informatics (2026)

BIOINFORMATION
Discovery at the interface of physical and biological sciences

BIOMEDICAL INFORMATICS

www.bioinformation.net

Volume 22(10)

Review

Received October 1, 2026; Revised October 31, 2026; Accepted October 31, 2026, Published October 31, 2026

DOI: 10.6026/973206300226898

SJIF 2026 (Scientific Journal Impact Factor for 2026) = 8.478
2022 Impact Factor (2023 Clarivate Inc. release) is 1.9

Declaration on Publication Ethics:
The author's state that they adhere with COPE guidelines on publishing ethics as described elsewhere at https://publicationethics.org/. The authors also undertake that they are not associated with any other third party (governmental or non-governmental agencies) linking with any form of unethical issues connecting to this publication. The authors also declare that they are not withholding any information that is misleading to the publisher in regard to this article.

Declaration on official E-mail:
The corresponding author declares that lifetime official e-mail from their institution is not available for all authors

License statement:
This is an Open Access article which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly credited. This is distributed under the terms of the Creative Commons Attribution License

Comments from readers:
Articles published in BIOINFORMATION are open for relevant post publication comments and criticisms, which will be published immediately linking to the original article without open access charges. Comments should be concise, coherent and critical in less than 1000 words.

Disclaimer:
Bioinformation provides a platform for scholarly communication of data and information to create knowledge in the Biological/ Biomedical domain after adequate peer/editorial reviews and editing entertaining revisions where required. The views and opinions expressed are those of the author(s) and do not reflect the views or opinions of Bioinformation and (or) its publisher Biomedical Informatics. Biomedical Informatics remains neutral and allows authors to specify their address and affiliation details including territory where required.

Edited by Ritik Kashwani
E-mail: docritikkashwani@yahoo.com
Citation: Mohan *et al*. Bioinformation 22(10): 6898-6902 (2026)

VIP syndrome in oncology: prevalence, forms and ethical implications - A review

Dinesh Mohan[1], Manmohan Manmohan [2], Sangram Keshari Patro[3], Pooja Khandelwal[4], Yogesh Prakash Garud[5], Antaryami Sahoo[6,*] & Abhinn Miglani[7]

[1]Department of Surgical Oncology, IMS & SUM Medical College, SOA University, Bhubaneswar, Odisha, India; [2]Department of Pathology, Pt. Bhagwat Dayal Sharma University of Health Sciences (UHS), Rohtak, Haryana, India; [3]Department of Surgical Oncology, UTKAL Hospital, Bhubaneswar, Odisha, India; [4]Department of Surgical Oncology, All India Institute of Medical Sciences (AIIMS), Sijua, Patrapada, Bhubaneswar, Odisha, India; [5]Department of Surgical Oncology, Garud Hospital, Maharashtra, India; [6]Department of Radiation Oncology, All India Institute of Medical Sciences (AIIMS), Bhubaneswar, Odisha, India; [7]Department of Oral and Maxillofacial Surgery, Institute of Dental Sciences, SOA University, Bhubaneswar, Odisha, India; *Corresponding author

Affiliation URL:
https://www.ims.ac.in/

ISSN 0973-2063 (online) 0973-8894 (print)
Bioinformation 22(10): 6898-6902 (2026)
©Biomedical Informatics (2026)

https://utkalhospital.com/
https://utkalhospital.com/speciality/surgical_oncology
https://aiimsbhubaneswar.nic.in/
https://www.garudcancerhospital.com
https://www.soa.ac.in/oral-and-maxillo-facial-surgery

Author contact:
Dinesh Mohan - E-mail: dineshmohan1009@gmail.com
Manmohan Manmohan - E-mail: manmohanyadav418@gmail.com
Sangram Keshari Patro – E-mail: jitun.04hell@gmail.com
Pooja Khandelwal - E-mail: pooja.khandelwal77@gmail.com
Yogesh Prakash Garud - E-mail: garudyogesh35@gmail.com
Antaryami Sahoo - E-mail: drantaryamisahoo2020@gmail.com
Abhinn Miglani - E-mail: abumiglani@gmail.com

Abstract:
VIP syndrome refers to the preferential treatment of influential patients, posing ethical and clinical challenges in oncology where equitable resource allocation is essential. Therefore, it is of interest to examine the prevalence, manifestations and ethical implications of VIP syndrome in cancer care by synthesizing evidence from recent literature across diagnostic, therapeutic and administrative domains. Preferential treatment was reported most frequently in academic cancer centres, with administrative deviations predominating, followed by therapeutic and diagnostic deviations. This review advances current knowledge by consolidating contemporary evidence on VIP syndrome in oncology and highlighting institutional safeguards, standardized care pathways and ethics education as key strategies for promoting equitable, evidence based cancer care.

Keywords: Very important person (VIP) syndrome, oncology ethics, preferential care, healthcare equity, cancer care delivery

Background:
Very important person (VIP) syndrome is a clinical phenomenon in which a patient's ability to influence healthcare professionals through institutional power, reputation, or professional standing leads clinicians to deviate from normal diagnostic or therapeutic care, sometimes resulting in poorer-quality care **[1]**. The literature describes VIP syndrome as favouritism extended to influential persons, including political figures, celebrities, donors, or healthcare professionals themselves, manifesting as accelerated access, distorted clinical judgment, or excessive accommodation of patient preferences. Although intended to provide optimal or personalized care, such preferential practices can paradoxically increase clinical risk, introduce inequity and compromise professional integrity **[2]**. Recent scholarship understands VIP syndrome as a distortion of clinical judgment under the pressure of rank, reputation and professional identity, particularly when clinicians treat colleagues or prominent members of society. There is empirical evidence that physicians frequently face pressure to alter standard care for VIP patients-for example, scheduling them more promptly, prioritizing them during diagnosis, or limiting open discussion of less favorable outcomes **[3]**. These observations suggest that VIP syndrome remains a practical, recurring ethical challenge in contemporary healthcare rather than a purely theoretical concern. Oncology is particularly susceptible to VIP syndrome, as cancer care involves high-stakes decisions, multidisciplinary coordination and emotionally charged prognoses **[4]**. Reports of expedited operations, omitted preoperative optimization, or non-adherence to recommended therapy for VIP patients illustrate how preferential treatment can expose influential patients to elevated perioperative risk or reduced oncologic benefit **[5]**. Oncology is also closely tied to access to scarce or experimental treatments, clinical trials and costly technologies, making questions of distributive justice and resource allocation especially salient. Although VIP syndrome is attracting growing attention in healthcare ethics, evidence specific to oncology remains fragmented, consisting largely of case discussions and broad commentary rather than consolidated synthesis **[6]**. Therefore, it is of interest to examine the prevalence of VIP syndrome in oncology, classify its manifestations across diagnostic, therapeutic and administrative domains and evaluate the associated ethical dilemmas, with the aim of supporting equitable, evidence-based oncology practice.

VIP syndrome in oncology:
In ethics literature, VIP syndrome is generally understood as preferential treatment of socially influential patients that results in impaired clinical judgment or avoidance of standard procedures. In oncology, this definition requires contextualization, since cancer treatment inherently involves individualized treatment planning. The defining feature of VIP syndrome is therefore not personalization itself, but unwarranted departure from evidence-based or institutionally established care pathways that is attributable to patient status rather than patient need **[7]**.

Theoretical foundations:
Three theoretical lenses help explain VIP syndrome in oncology. First, power-asymmetry theory holds that clinicians adjust behaviour toward patients perceived as socially or institutionally

dominant, producing deference or over accommodation. Second, professional-boundary theory suggests that treating colleagues, donors, or high profile individuals blurs the clinician patient relationship, increasing the risk of nonstandard decisions. Third, organizational pressure theory points to institutional incentives philanthropy, prestige, or political influence that indirectly promotes preferential access. In oncology, multidisciplinary care delivery and resource intensity together heighten susceptibility to these effects **[8]**.

Oncology-specific drivers:

Oncology presents structural conditions that aggravate the risk of VIP syndrome: limited resources (advanced imaging, radiotherapy slots and clinical trials), emotionally charged prognostic uncertainty and a multi-step treatment sequence. These features create numerous decision points at which influential patients may receive preferential treatment or different advice. Oncology teams are also frequently exposed to high-profile patients and physician-patients, increasing exposure to hierarchical pressures **[9].** The conceptual domains and underlying drivers of VIP syndrome in oncology are summarized in **Table 1.**

Conceptual domains of VIP manifestation:

Drawing on the available literature, VIP syndrome in oncology can be organized into three domains: diagnostic, therapeutic and administrative. Diagnostic manifestations involve pathway deviations during testing; therapeutic manifestations involve deviation from guideline concordant treatment; and administrative manifestations involve biased accessibility or resource distribution. These domains provide an analytic framework for synthesizing the findings of this review **[10].**

Findings from the literature:

Overview of the reviewed literature:

The body of literature reviewed reflects a rising number of publications since 2020, indicating growing interest in the ethics of preferential care in oncology. Geographically, North America was the most frequently represented setting, followed by Europe and the Asia-Pacific region, with limited representation from low- and middle-income countries. Surgical, medical and radiation oncology were all represented, alongside mixed multidisciplinary settings and the literature spanned empirical observational research, qualitative or interview-based studies, case analyses and ethics or policy discussion **[11]**.

Prevalence of VIP syndrome in oncology:

Reported frequency of VIP-related preferential care varied considerably across the literature; nevertheless, most sources reporting on this question described VIP syndrome as a recurrent or common feature of oncology practice, particularly at academic cancer centres, where exposure to physician-patients, donors and public figures is greater. Occasional or anecdotal manifestations were also described, suggesting a spectrum of frequency rather than a uniform pattern. Healthcare professionals, major donors, political or governmental figures and celebrities or other high-profile individuals were the patient groups most often associated with VIP status **[12]**. The principal manifestations reported across diagnostic, therapeutic and administrative care domains are summarized in **Table 2.**

Outcomes and consequences:

Reported outcomes of VIP care were largely negative or ambivalent. Clinical risks described included delayed standard treatment, procedural complications arising from bypassed optimization and inappropriate therapy exposure, alongside safety concerns linked to reduce care coordination when usual pathways were not followed. Qualitative literature consistently characterized professional distress among clinicians, including moral discomfort, role conflict and a sense of coercion, while preferential care more broadly was linked to perceived inequity and resource strain across oncology services **[13]**.

Ethical challenges identified:

Literature addressing ethical dimensions of VIP syndrome identified violations of distributive justice arising from unequal access and priority, alongside distortion of patient autonomy where clinicians avoided full prognostic disclosure or found it difficult to decline VIP requests. Institutional or hierarchical pressures were repeatedly linked to nonstandard care and resulting conflicts with professional integrity, with institutional drivers such as donor relationships or reputational concerns described as a recurrent theme intensifying VIP syndrome within oncology organizations **[14]**. Corresponding ethical principles and proposed mitigation strategies, including professional boundaries, care standardization, conflict-of-interest management, transparent resource allocation and clinician training, are presented in **Table 3.**

Table 1: Conceptual domains and drivers of VIP syndrome in oncology

Domain	Description	Typical Manifestations in Oncology	Underlying Drivers
Diagnostic	Status-driven alteration of diagnostic processes	Expedited imaging/biopsy; bypassing referral pathways; over- or under-testing	Deference to influential patients; fear of delay criticism
Therapeutic	Deviation from guideline-based treatment decisions	Non-standard therapy selection; premature or delayed treatment; access to experimental therapy	Role conflict; desire to satisfy VIP expectations
Administrative	Preferential access to services or resources	Fast-tracked appointments; priority operating room or radiotherapy slots; senior clinician assignment	Institutional pressure; prestige or donor influence

Table 2: Forms of VIP syndrome in oncology, by care domain

Domain	Relative Frequency in Literature	Common Manifestations
Administrative	Most frequently reported	Fast-tracking; resource priority; senior clinician assignment

Therapeutic	Frequently reported	Guideline deviation; over/under treatment; experimental access
Diagnostic	Less frequently reported	Expedited imaging/biopsy; bypassed referrals; over/under-testing

Table 3: Ethical and policy strategies to mitigate VIP syndrome in oncology

Domain	Risk Addressed	Ethical Principle	Recommended Strategy
Professional boundaries	Role conflict, deference	Integrity	Independent care teams; transparent documentation
Care standardization	Guideline deviation	Beneficence, justice	Mandatory protocol adherence; MDT review
Conflict of interest	Donor/institutional pressure	Justice	Disclosure; separation of fundraising and care
Resource allocation	Scheduling priority	Distributive justice	Transparent criteria and audits
Training	Clinician vulnerability	Professional ethics	VIP ethics education and simulations

Interpretation of prevalence and manifestations:
The recurrence of VIP syndrome reported across the literature, particularly at academic cancer centres, suggests that the phenomenon may be under-recognized rather than rare, especially since most sources relied on qualitative or perception-based reporting rather than objective measurement. Regional and institutional variation further suggests that VIP prevalence is shaped by healthcare system structure, financing models and organizational culture **[15]**.

Institutional and organizational drivers:
A central finding of this synthesis is that VIP syndrome in oncology is largely a systemic phenomenon shaped by institutional incentives. Academic cancer centres reliant on philanthropy, prestige and public visibility may experience indirect pressure to accommodate donors or public figures, with administrative structures sometimes reinforcing pathways for preferential scheduling or decision-making. Institutions with clearer governance structures appear better positioned to limit, though not eliminate, status-based effects, suggesting that mitigation should focus on structural governance rather than individual ethical vigilance alone **[16]**.

Comparison with the broader healthcare literature:
Compared with the general healthcare literature, VIP syndrome in oncology shares core mechanisms status influence, blurred professional boundaries and institutional pressure but carries amplified ethical and clinical stakes, given that oncology decisions are often life threatening, time-sensitive and resource constrained. The multidisciplinary structure of cancer care also creates more decision points at which VIP influence can operate, from diagnostics through treatment planning to follow-up, making the equity and outcome implications of VIP syndrome especially visible in this setting **[17].**

Practice implications:
These findings point to the need for institutional mechanisms governing the care of VIP patients in oncology. Standardized scheduling and treatment pathways, along with consistent trial eligibility criteria, can help minimize preferential deviation and multidisciplinary tumor boards should maintain protocol compliance regardless of patient status, with any necessary deviation clearly documented and explained. Ethics consultation services and ongoing education on professional boundaries and equity principles can support clinicians under VIP-related pressure, while at a policy level, oncology organizations should ensure that resource distribution is guided by clinical need rather than social influence **[18]**.

Ethical and policy implications:
The literature reviewed suggests that VIP syndrome in oncology is fundamentally an ethical and governance issue requiring both institutional and professional responses. Addressing it requires clear ethical guidance, organizational safeguards and educational approaches that support fair, protocol-concordant cancer care **[18]**.

Professional boundaries and standardization:
Maintaining clear professional boundaries is central to mitigating VIP syndrome. Treating colleagues, donors, or high-profile individuals carries risks of role conflict and deference that may distort clinical judgment; ethical guidance therefore emphasizes avoiding dual relationships and managing influential patients through standard care teams rather than exceptional channels **[17]**. Standardization of oncology pathways referral, staging and multidisciplinary review-helps ensure that any necessary individualization is grounded in clinical need rather than social status **[19]**.

Institutional safeguards:
Institutional conflicts of interest, often linked to philanthropic relationships or prestige concerns, are a key driver of VIP syndrome in academic oncology centres. Clear governance on disclosure and management of such conflicts, including separation of fundraising relationships from clinical decision-making, can reduce preferential pressure. Formal VIP patient policies that define expectations, prescribe standard care processes and clarify how special requests are handled have been associated with more consistent decision-making in high-profile cases **[20]**.

Equity and resource allocation:
Because VIP syndrome directly challenges distributive justice in settings where advanced treatment, clinical trials and specialized services are limited, oncology governance should prioritize clinically grounded, transparent allocation criteria over status-based access. Auditable prioritization processes for surgery, radiotherapy and systemic therapy can support fair allocation, while transparent, publicly accountable distribution policies help sustain institutional trust **[21]**.

Training and awareness:

Resistance to VIP-related pressure can be strengthened through education addressing professional boundaries, equity principles and recognition of status-driven bias. Simulation-based ethics training has been shown to improve clinician confidence in managing high-profile patient situations and such training should extend to administrators and schedulers, since VIP influence often operates through organizational as well as clinical channels **[20, 21]**.

Limitations of the review:

Several limitations should be considered when interpreting this review. As a narrative rather than systematic review, the search and selection process was not exhaustive and may be subject to selection bias. The abstract and heterogeneous character of VIP syndrome also presents a challenge for synthesis: there is no standardized operational definition and the literature uses varied terminology, including VIP patients, physician-patients, preferential care and high-profile patients, which may have affected consistency in identification and thematic classification. Most of the literature reviewed was qualitative or case-based rather than quantitative empirical research and where frequency data were reported, they relied largely on clinician perception or institutional experience rather than objective measurement; reported prevalence should therefore be regarded as indicative rather than definitive. Geographic representation was also uneven, with most sources originating in North America and Europe and limited evidence from low- and middle-income countries, where differences in resource availability and institutional culture may shape VIP dynamics differently. Finally, publication bias is plausible, since preferential treatment of influential patients is a reputational sensitive topic that institutions may be reluctant to document; the literature reviewed may therefore under- or over-represent certain practice patterns relative to reality. Despite these limitations, this review offers a structured synthesis of available evidence on VIP syndrome in oncology and identifies consistent patterns across diverse settings.

Conclusion:

VIP syndrome in oncology compromises patient safety, equitable access, and evidence-based care. Administrative, diagnostic, and therapeutic deviations highlight the need for standardized protocols and institutional safeguards. Future research should assess prevalence, clinical outcomes, and strategies to ensure fair oncology care.

References:

[1] Alkhawaldeh IM *et al. Qatar Med J.* 2024 **2024**:68. [PMID: 39534271]
[2] Gershengoren L. *J Grad Med Educ.* 2016 **8**:784. [PMID: 28018552]
[3] McCann L & Granter E *et al. Journal of Professions and Organization*. 2019 **6**:213 [DOI: 10.1093/jpo/joz006]
[4] Rockwell H *et al. Semin Intervent Radiol.* 2022 **39**:454. [PMID: 36406034]
[5] Tse A *et al. Healthcare (Basel).* 2025 **13**:2429. [PMID: 41095515]
[6] Di Maio M *et al. Oncologist.* 2020 **25**:e746. [PMID: 31872939]
[7] https://pubmed.ncbi.nlm.nih.gov/42015670/
[8] Park T *et al. J Eval Clin Pract.* 2026 **32**:e70655. [PMID: 42836826]
[9] Ray M & Kottu HS. *Oncol Rev.* 2025 **19**:1683378. [PMID: 41180135]
[10] Bogaert B *et al. Crit Rev Oncol Hematol.* 2022 **173**:103656. [PMID: 35337970]
[11] Yeh P-J *et al. Front. Pediatr.* 2020 **8**:430. [PMID: 32850544]
[12] Sharma D. *Postgrad Med J.* 2026 **19**:qgag058. [PMID: 42152804]
[13] Luo X *et al. J Eval Clin Pract.* 2026 **32**:e70599. [PMID: 42743406]
[14] Darbari A. *Indian J Surg*. 2012 **74**:407. [PMID: 24082595]
[15] Avinger AM *et al. JAMA Netw Open.* 2022 **5**:e2236914. [PMID: 36255726]
[16] Sacre H *et al. Sci Rep*. 2025 **15**:36388. [PMID: 41107430]
[17] Unger JM *et al. Am Soc Clin Oncol Educ Book.* 2016 **35**:185. [PMID: 27249699]
[18] Brown M & Zhou AE. *J Clin Aesthet Dermatol.* 2023 **16**:57. [PMID: 38125670]
[19] Gentile S *et al. BMC Palliat Care.* 2025 **24**:196. [PMID: 40652223]
[20] El Bairi K *et al. JCO Glob Oncol.* 2024 **10**:e2400167. [PMID: 38822759]
[21] McIntosh JT. *Nurs Ethics*. 2020 **27**:809. [PMID: 31757188]

Caveat Emptor is applicable among the literate community where required and possible. The publisher, its journal, editors and the internal/external reviewers take adequate steps to check, evaluate, correct, edit, revise and improve content where possible and required.