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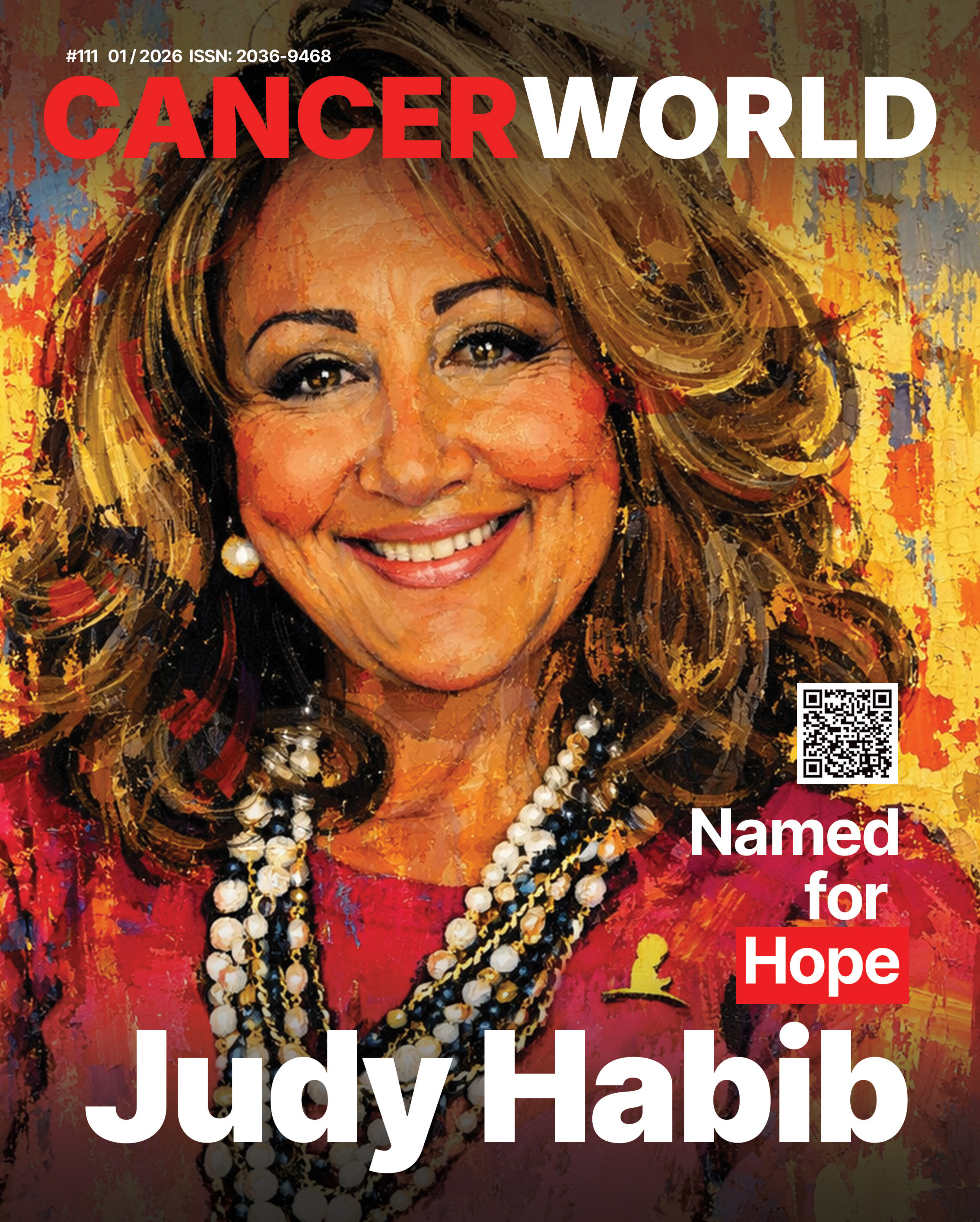

## Named for Hope

# Judy Habib

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on Hemostasis and Thrombosis

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NOT FOR SALE

## *Where progress is shaped by story, and leadership is measured by service*

*Every issue of CancerWorld explores the terrain where science meets humanity, where personal history informs public responsibility, and where progress in cancer care is defined not only by innovation, but by values. This issue brings that mission into sharp focus through two cover stories that could not be more different in form, yet are profoundly aligned in spirit.*

*Our first cover story is **Judy Habib**: **Named for Hope**, a portrait that unfolds across memory, leadership, faith, and strategy. Named after St. Jude, the patron saint of hopeless causes, Judy Habib grew up inside the living history of St. Jude Children's Research Hospital and ALSAC. From Danny Thomas' vow that "no child should die in the dawn of life," to the creation of one of the world's most powerful philanthropic engines, her story reveals how movements are built: through integrity, storytelling, shared ownership, and the discipline to protect purpose as scale grows. As Chair of the Board of Governors of St. Jude, Judy Habib embodies a rare both/and leadership, finding cures and saving children, strategy and soul, ambition and humility.*

*Our second cover story takes us from a mountain village in Lebanon to the heart of European health reform. **Dr. Hosams Abu Meri**, gastroenterologist and Minister of Health of the Republic of Latvia, represents another form of service-driven leadership. Still performing endoscopies on weekends, still listening to patients firsthand, he governs with the lived awareness of clinical reality. From lowering medicine prices and rebuilding a depleted workforce, to strengthening cancer screening, digital health, and prevention policies, the Minister shows how credibility is earned when policy never drifts too far from the clinic.*

*From these two cover stories, the issue unfolds into a wide-ranging exploration of what sustainable, equitable cancer care truly requires.*

***Dr. Dario Trapani** examines the architecture of equitable innovation, asking how value-based oncology, dose optimisation, and economic modelling can transform sustainability from a technical constraint into a moral commitment.*

***Prof. Andrea Filippi** offers a deeply human portrait of modern radiotherapy, precise with cancer, gentle with people, where de-escalation, inclusion of fragile patients, and thoughtful leadership redefine what excellence looks like.*

***Ingrid Krücken** reminds us that survivorship is not an afterthought, but a phase that demands justice, empathy, and structural protection, from the right to be forgotten to real support for families in crisis.*

***Dr. Jan van Meerbeeck** reframes cancer screening as an issue of equity, not only evidence, challenging Europe to move from proof to implementation without leaving the most vulnerable behind.*

***Adrian Pogacian** turns the lens inward, asking what unchecked emotional labor costs oncology professionals, and why learning to analyse our own emotions may be one of the most urgent tasks of 2026.*

***Dr. Luca Bertolaccini** explores how artificial intelligence is entering the tumour board, not as a decision-maker, but as a disciplined tool that can sharpen judgment if governed with rigor and ethics.*

*This is an issue about **hope with structure, leadership with memory, and reform with humanity.***

***Yeva Margaryan, Managing Editor, CancerWorld***


St. Jude Children's Research Hospital
ALSAC • Danny Thomas, Founder
Finding cures. Saving children.

# Judy Habib

## Named for Hope

By Gevorg Tamamyan

“Yes,” she said. “I was named Judy after St. Jude.”

When she was old enough to learn who St. Jude was, she remembers the moment it landed with a child’s blunt logic.

“When I became old enough and learned about the saints and that St. Jude was helper of the hopeless, I said to my parents… What, you named me for some… hope? Was there a problem that you named me after the patron saint of hopeless cases?”

But the truth was simpler and deeper.

“The reality is that both my parents were devotees of St. Jude,” she said. “They both loved St. Jude.”

Her mother’s devotion came from a family story that never left them. Judy’s Aunt Laurice, her mother’s sister, had what sounded like leukemia or a blood disease, at a time when diagnoses were vague and outcomes were brutally clear.

“Her prospects were dismal,” Judy said. “My mother… found St. Jude and prayed to St. Jude, and her sister recovered.”

“Doctors said that she would never have a full life and children,” Judy recalled. “And yet she went on to get married and have four children and live… into her 90s." "That's why I was named after St. Jude!"

Currently, Judy Habib is serving her third year as Chairperson of the Board of Governors of St. Jude Children's Research Hospital. In 2019-2021, she chaired the Board of Directors for ALSAC, American Lebanese Syrian Associated Charities, the world's largestworld largest pediatric cancer charity, today raising around 3 billion dollars a year for St. Jude.

## Danny Thomas and How it All Started

Her father's connection to St. Jude went much further back, to the earliest days of Danny Thomas' vision.

"My father was one of the early disciples of Danny Thomas." Judy retold the story as something more than history; she described it as a blueprint of how movements start: promise, integrity, and a vision big enough to attract the right people.

Danny Thomas, she explained, had made a vow: he would build a shrine for St. Jude if St. Jude "would show him his way in life." As his success grew, his promise expanded too. He didn't just want to build a shrine; he wanted to build something that would change the fate of children.

"He had always been painfully aware of the inequity of healthcare for children," Judy said. "If they were not of means… poor, black… end of the line, back of the room, not getting treated."

Children were dying of things they didn't have to die from.

So, Danny went to Cardinal Stritch in Chicago and said he wanted more than a shrine, he wanted a clinic for children, "regardless of their means… their color… their anything. All children should have healthcare."

Cardinal Stritch had a Memphis connection, she noted, and introduced Danny to John Berry, "an amazing businessman," who then brought in Dr. Lemuel Diggs.

And it was Diggs who changed the architecture of the dream.

"Dr. Lemuel Diggs said, 'Danny, instead of a clinic, why not build a research hospital and find the cures for these catastrophic diseases… like sickle cell anemia, and leukemia…'"

Danny's response was almost disarmingly simple.
"And Danny was like, 'Okay, sounds like a good idea—so now what?'"

## "No Child Should Die in The Dawn of Life"

At this point, Judy leaned into what she called the "magic" of it all, not magic as mysticism, but magic as execution: a promise honored, a vision held, and an openness that lets the right people shape the "how."

"As I think about magic," she said, "the purity of someone making a promise, having the integrity to fulfill thefulfill on the promise… having a vision for something possible… being open to what comes, and trusting that the right people come at the right time…"

She described how momentum forms: one person contributes an idea, another adds infrastructure, another adds expertise. And the leader, if the leader is real, has the ability to listen and adjust without losing the purpose.

"He had the ability to say, "Okay, I hear what you're saying, that makes sense, say more.'"

And at the center of it, a statement that is less a slogan than a moral position:

**"That no child should die in the dawn of life."**

## ALSAC: "Saying Thank You to America."

Vision needed money. And early on, Judy said, Danny tried what many founders try first: his immediate circle.

"He had a couple of dinners with his celebrity friends, and raised… 100, 200 thousand dollars," she said.

Then reality hit.

"After a couple of years, he said, 'This is not sustainable… maybe we need to have the nuns take it over, because they know how to build and run hospitals. I don't.'"

That's when a friend, Mike Tamer, offered an idea that was part fundraising strategy, part community identity.

"Our people are new to this country," Judy quoted him. "People don't know Aboussie, Haddad, Hajar, Habib… they know Smith, Jones, Reilly…"

And then the line that became a purpose statement:

"This would be... our way of saying thank you to America." Danny liked it.

So instead of flying— because the movie studios felt it was too risky at the time—Danny and his wife, and Mike Tamer, got into a station wagon and drove from Beverly Hills to Boston, "and everyplace in between," collecting what Judy called "his disciples."

Then Danny did something Judy still talks about as a leadership case study.

"He disseminated leadership," she said.

He would go city by city—Cleveland, Chicago—and effectively say: you're in charge.

"I don't care how you do it," he would say. "We gotta raise money."

And then, in a sentence that captures both the bluntness and the urgency of building something impossible:

"Have your chicken dinner, have your golf outing—stand on your head and spit nickels—I don't care. Raise money. Figure it out. But you're in charge."

Judy paused and then added something important: this wasn't just a mechanism. It created pride. It created belonging. It created speed. It was 1957, and ALSAC was born.

"There are certain things that he just did by gut instinct," she said, "but I look back and say this should be a case study in the Harvard Business School."

## Two Organizations, One Mission

Judy grew up with St. Jude as a family reality, not a distant institution.

"I was very young when my father would go to board meetings," she said, "but every year we would go to these ALSAC conventions."

ALSAC, American Lebanese Syrian Associated Charities, was created with one clear purpose: raise funds and awareness for St. Jude.

And Judy emphasized a structural decision that mattered: ALSAC and St. Jude were distinct, but interdependent.

"He created these two organizations... but the same people served on both boards.

"All ALSAC worried about was raising money and awareness," she said. "And St. Jude was about... finding cures and saving children."

At those conventions, she watched an early version of institutional learning in real time: cities sharing "best practices," what worked, what failed. Doctors updating the community: what they were studying, how cure rates were improving, what equipment or buildings were needed next. And one constant refrain:

"We have to raise more money... we have to raise more money..."

But there was never a question of whether St. Jude would get what it needed.

"Danny would say, 'Whatever they need, ALSAC is going to get it for them—we'll just figure it out.'"

## A Young Woman, Nursing, and The Moment Reality Disagreed

Judy's own career path started in the world her generation was offered.

"At the time that I was growing up, little girls grew up and they were teachers, nurses, and secretaries."

Her father was the first in his family to go to college. He wanted to be a doctor. He became an obstetrician-gynecologist. She thought: I'll be a nurse.

"I'm going to go to Boston College, then the best nursing school in the country," she said, "and we'll all live happily ever after."

Judy took summer jobs as a nurse's aide.

"I loved being a nurse's aide, I loved the interpersonal contact with patients."

But once she was in college and started clinical rotations, her perspective changed. The system didn't match the ideal.

"The healthcare system was not what I had imagined it to be. Not... the integrated healthcare team, centered around the patient... It just wasn't like that in the real world."

And she saw something else: undervaluation.

"I felt that nurses were really undervalued, perceptually and financially," she said.

So, she made a decision that many people feel but few name so directly:

"I really felt like I was either going to need to transform the nursing profession or come up with plan B."

## Business, Storytelling, and "The Gift of Not Knowing"

**Plan B became business.**

She made an appointment with the Dean of the School of Management at Boston College, and even that entry started with persuasion.

The dean challenged her: "Why would a nice girl like you want to leave nursing?

"After a couple of hours," Judy said, "he said, 'Alright… you've sold me on this… I guess you can sell anybody anything.'"

Her first job was in sales for Scientific Products, a division of American Hospital Supply, supplying research laboratories.

"The irony," she said, "was that when I was in nursing school, I did not love labs. And my very first job was spending all my time calling on laboratories."

After five years of record-breaking sales achievement (and the first woman in the industry), she left to test her entrepreneurial wings with a start-up. Although it was a great experience, she knew it was time to go corporate. She landed a role in strategic planning and loved it. But after a couple of years, the head of sales and marketing asked to lead marketing communications.

Judy asked him, "I love what I'm doing now. Why do you want me to take over marketing communications?"

The answer was practical.

"Because you understand strategy, you understand sales… we have 200 salespeople, and they need better support… I trust you… and you need the management experience." It turned out to be a great move, she worked with world-class agencies, and the company reached new heights of recognition.

But after five or six years, she reached a breaking point many high performers recognize.

**"I was tired of the bureaucracy of corporations, tired of politics."**

She knew what she actually loved:

**"What I loved was… helping people and organizations see and realize what's possible."**

And she realized that the lever for that is language.

"I realized the importance of telling a good story. And that it's all about communication."

So, she left the safety of the corporate world and launched what others might call an ad agency, but she refused the label.

"I called this company like the Uncola of advertising agencies," she said, "because it wasn't just about advertising."

It was about helping organizations "understand and tell their own story" so, people would want to join, buy, support, commit.

**"It all begins with 'how are you telling your story?'"**

Her firm, Kelly Habib John (KHJ), was built with commitment more than certainty.

"We had no roadmap for what we were taking on," she said, "but we were just really committed..."

Then she said something that reveals her as both builder and believer:
"The greatest gift is the gift of not knowing," she said. "I never worked in an agency, and I started one."

**"But God gave me a good brain," she added, "and a really high empathy listening for what there is to do... what there is to see... what there is to hear... and then what there is to say."**

They "figured it out," built a strong independent firm, employed many people, and told "some really good stories... for wonderful companies" over three-plus decades.

## Bringing Her "Adult Professional Self" to St.Jude: Reputation vs Brand

St. Jude was always part of her life. But she reached a point where she asked: how can I contribute more?

She joined the marketing committee. Within a year, she was asked to join the board.

And when she arrived with professional eyes, she saw something powerful yet incomplete.

"What I saw was an organization that was doing amazing things, and... it had a great reputation."

But the communications were fragmented.

"There was the St. Jude logo. It was in red, blue, green, different shapes and sizes, type fonts, and lots of pretty colorful flyers."

"It was functional, but all over the place," she said.

So, she made a presentation to the board and leadership about a distinction she clearly believes every mission-driven organization must understand:

**"You need to understand the difference between reputation and brand."**

"Reputation is what people experience of you," she said. "We have a wonderful reputation because... families... come in with a sick child and go home with a child that's going to be okay."

Fundraisers felt proud; donors felt meaning; outcomes were real. Reputation was deserved.

But the brand was now their responsibility.

"Our founder... isn't going to be here forever," she said. "We need to pay attention to something called a brand."

And she defined brand in a way that is both simple and strategic:

"Brand is how you are being responsible for how people think and feel when they see or hear your name."

It's "being very deliberate" about how you look, how you speak, organized with consistency so reputation becomes momentum.

"You're putting an engine to it," she said, "so that you can accelerate the momentum."

Her company KHJ did pro bono work for St. Jude, refining its logo "so that it could always look the same way," while keeping "the essence of the original."

And she pointed to two lasting outcomes she's proud of: the consistent logomark "with the beautiful child" that "is what you see today.", and the positioning line that became a global signature:

**"Finding cures. Saving children."**

She smiled and paused.

## **Judy Habib:** Both/And

When Judy Habib speaks about St. Jude, she doesn't speak like a board chair describing governance. She speaks like someone who grew up watching a living organism, built on story, tension, pride, and purpose, learn how to scale without losing its soul.

As a child, she would attend the ALSAC conventions with her parents. And there was one privilege that shaped her early understanding of leadership: families were allowed to sit at the edges of the boardroom.

"We'd be in a hotel... a big ballroom," she said. "The board members were all at a table and we got to sit on the outside and watch the boardroom.

It was so amazing to see these mostly men... many of them of Middle Eastern heritage... arguing about how something was going to go forward and how we were going to allocate the budget."

And the arguments, she said, were not about ego. They were about mission, about where the money should go.

**"No, there should be this much money for research."**
**"No, you should put this much money more to treatment."**
**"No, it should be this program... to find the next cure."**
**"No, it should be this because we have to make sure that the patients..."**

"It was always this sort of battle and tension," she said. "Research, clinical, research, clinical."

Even back then, everyone knew the secret of St. Jude: "the magic... is the bench to bedside translation." But inside the boardroom, the question kept returning in different forms: Is it this? Is it that?

That tension is what gave birth to one of the most recognizable brands in global healthcare.

"When we were thinking about the brand," Judy said, "I said, you know what? It's not either/or."

"The essence and beauty of the place is that it is both/and—and it shall always be **both/and.**"

And then she said the sentence that, in her mind, holds the identity of the institution:

"Because who we are and what we are about is finding cures and saving children."

"Let us always remember that it's a both/and—**finding cures, saving children**," she said.

She smiled when she described what happened over time. "I'm very pleased to say today... the public recognizes just that tag-line. Seventy-five percent of the public says, 'Oh yeah, finding cures, saving children. That's St. Jude.' It's very thrilling."

"And it remains so to this day," she added. "It really is who we are and how we speak."

## "There's Only One Beginning to Something Great"

"Hearing the founders speak about the early days was so precious," she remembers. "It was like a little kid sitting at the knee of their grandparents... hearing stories that were just so precious."

Then she recognized a leadership risk that many organizations ignore until it's too late:

"These stories could not disappear. We could not let these

stories go away with our founders going away."
Because, she said, a great brand isn't only a logo or a slogan.

"It has an essence. It has a soul."

She compared it to something timeless: the way Native American storytelling carries meaning across generations.

"They tell stories and the stories go from generation to generation."

So, she built an archive, not with documents, but with a film.

She called a producer friend, Peter Ryan, and asked him to volunteer his talent.

"I want us to create a film... capturing the stories of this founding generation, because they are precious."

"And there's only one beginning to something great," she added. "You never want to lose the story of the beginning."

They interviewed 25 of the earliest "disciples" and created a 35-minute film called **The Dream**, a portrait of immigrant identity, gratitude, community, and national mobilization behind Danny Thomas.

"It really does tell the story of what it was like to be new immigrants to America... what it was like to come together nationally and get behind their hero... and create this great St. Jude."

She described specific voices she still hears from the film: "Emil Reggie from New Orleans... 'Roots, roots. You can never forget your roots... If you don't have roots, you're nobody.'"

And Peter Decker, "the singing attorney from Virginia," speaking about Lebanese people and their "purity of heart."

"These were not people of wealth," Judy emphasized. "They were doing it because they were so present to the gift it was to be in a place where they could see and realize possibilities for their families."

"They wanted to give back," she said. "And St. Jude was the way."

She believes the film should be institutionalized.

"It's something that I believe probably could and should be shown to every employee... so that you just never let it be forgotten how it began."

## Sophistication Without Losing Heritage

Decades serving on the board gave Judy a front-row view of two evolutions happening in parallel: St. Jude and ALSAC growing larger, more complex, and more professional, and the board needing to keep up.

"We started looking at ourselves and saying, we need to grow in sophistication to ensure that we are properly governing these two organizations," she said.

"But we can never lose our heritage."

Here Judy credited Marlo Thomas as a guardian of the founding identity.

"Marlo Thomas was probably the biggest advocate of ensuring that that would never happen," Judy said - so much so that Marlo supported a bylaw requiring a significant percentage of the board to remain Lebanese-Syrian in heritage.

"We will never lose the ALSAC/St. Jude connection, and our heritage should always be a point of pride... because one of her father's intentions was that this would be our way of giving back."

But that principle didn't mean staying small or insular. So, they have been "pruning and curating," evolving board composition to bring in expertise, people who can ask the second, third and fourth questions when management brings proposals for consideration.

"We are committed to have the full sophistication and experience of a world-class board to govern these world-class organizations."

## The Challenge that Never Goes Away

When I asked Judy what has been most challenging throughout the decades, she went right back to the original boardroom energy she watched as a child.

"The challenge today... is no different from what the challenge was on day one," she said.

"Competing passions for what's next and how it should be."

That passion looms large in both St. Jude and ALSAC, and also inside the boardroom itself.

"There's such a voracious appetite for so much to occur." Board size was part of the complexity. Today it's 31.

"At one time… in the early days, the board was as large as 55 people. Which is crazy. But it was a different time."

Still, she's clear on the practical logic: two distinct organizations, "two different businesses," with heavy governance load.

Their "sweet spot," she said, is "25 to 35."
And her job as Chair is not to eliminate passion, but to steward it.

"Managing the dynamic of all of those competing passions… that's what there is to do. So that people can leave the room at the end of the day and still want to breaking bread together, as they did in the early days."

## "Knowing Nothing and Bringing Everything"

When I asked what was key to her success, how a young woman who once planned to become a nurse became chair of the board of one of the world's most consequential pediatric cancer institutions, she answered with the same humility that runs through her whole story.

"Knowing nothing and bringing everything," she said.

"Listening really well and learning really fast."

She traced it back to KHJ, the company she built and led for 35 years.
"Helping people and organizations see and realize what's possible for themselves and the world around them."

Over three decades, she worked across Fortune 100 companies and startups, healthcare and biotech, finance and economic development, becoming, as she put it, a "student" of what works, what fails, what makes great leadership and culture.

And she returned to a line she had used earlier, one of her core beliefs:

"The greatest gift is the gift of not assuming that you already know."

"Sometimes I think that an attitude of 'I know' gets in the way of really astute listening and a kind of curiosity that can bring true understanding," she said.

She described her board work as "a labor of love." It's volunteer service, but deeply personal service.

And right now, the timing matters.

"I do feel a confidence that I am the right person at the right time for this board, because we are at a moment where we are passing the torch from our founders to our future."

And there's urgency in her voice when she explains why.

"We are the last people that got a hug from Danny Thomas… When we're gone, that's it."

So, the responsibility isn't only operational. It's cultural.

"How are we setting tracks for the future… culturally… how do we ensure that we always have that purity of purpose and passion for performance?"

"That can never go away," she said. "Because that is the secret of our success."

## "A Big Mountain to Climb"

Judy then widened the lens into a pattern she's observed across businesses as they mature: the founding generation is fueled by passion, second-generation is challenged to build on that foundation; the danger that faces the third generation is when success becomes comfortable.

"Complacence is the biggest killer to business," she said. "Complacency is a killer… you get comfortable… values can wane, and there are cracks in the foundation."

She explained how the second generation initially felt when taking the helm from the founders:

"We were scared. We're like, 'Holy God, it's up to us…'"

"Our number one job: just don't mess it up."

But they didn't just hold the line, they built.

**"We were raising… five, six hundred million dollars a year," she said. "And today… we're probably hitting three billion a year."**

"That's pretty amazing," she added, because it means millions of people are "enrolled in our story."

Then Judy pointed to a turning point in global ambition, when CEO Jim Downing pushed the institution beyond its success in America toward a more sobering global reality.

"Danny didn't say no child should die in the dawn of life in America. He said no child should die at thein the dawn of life."

The moral question that has become strategy and part mantra in the boardroom:

**"If not St. Jude, who? If not now, when?"**

And she described the beginning of what followed: Dr. Downing's commitment to recruit the best person to lead this next chapter of the St. Jude story – Carlos Rodriguez-Galindo.

At the St. Jude Global Convening she had just attended, Judy said she felt something familiar: the entrepreneurial spirit of the earliest ALSAC conventions.

"A big mountain to climb," she said. "We don't know exactly how... but we all care about the same thing."

"Let's share successes, share failures... connect the dots... come together... and get it to happen."

And she underlined what she believes is a defining St. Jude trait:

"There's never a complacence that it's done... There's always a humility... there's just so much more to do... and let's do it."

**"In The World of Good and Evil, in The World of Light and Dark, St. Jude is Good, and St. Jude is Light."**

When I asked what she envisions 10, 20, 30 years from now for St. Jude Global, she corrected the framing gently.

"When you say St. Jude Global, it's as if it's a program... But what I see is that St. Jude Children's Research Hospital is a global entity..."

She highlighted foundational science as the first pillar, especially at a time when government investment is not "as generous as one might hope."

"Discoveries begin there, and then it's built upon by everyone everywhere... no authorship on the discovery."

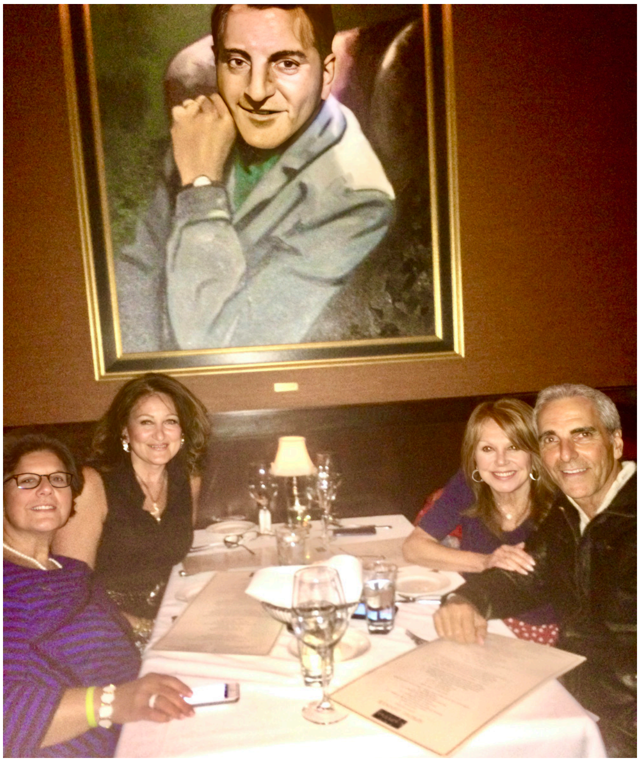
Touching on one of Danny Thomas's founding principles:

"We'll share our knowledge as soon as we get it."

Then she stopped herself when she almost used **the word "leader."**

"We're not about being the singular leader in anything," she said. "That has so much ego to it."

But she did describe what she believes St. Jude models: convening people with pure intention, openness, and a desire to collaborate for the greater good.



"A model for what it looks like to contribute in a world that is really humane."

And then she offered a moral statement, not a corporate one:

"In the world of good and evil, in the world of light and dark, St. Jude is good, and St. Jude is light."

Beyond science, Judy believes St. Jude generates another kind of knowledge: the knowledge of how to collaborate.

"How do you convene independent forces for a common good?" she asked. "And... share our knowledge in how to do that... because it can be applied in every way, everywhere."

## The Fifth Canvas, "Sawubona," and The Gift of Being Gotten

When I asked about books that shaped her, she surprised me by answering with a book she is working on but hasn't yet published.

"The book will be called **The Fifth Canvas.**"

Life, she explained, unfolds in "a series of canvases", stages that complete and open into the next. She began thinking this way while her best friend was dying of multiple myeloma.

She described the canvases as themes of a life: "The Road Less Traveled," "Relationship as sacred path," "Community," "Contribution," and then what she assumed would be the last canvas: "Completion."

But writing brought her to an unexpected punchline:

"If only we could get that we are really complete from our first breath as human beings... perfectly in-complete, always."

Then she named one book she used constantly as a CEO: **The Four Agreements**.

She described a ritual: reading a short excerpt with every new employee, not as management theater, but as a way of seeing.

"I wanted them to have that experience with me," she said. And she used a word she loves:

"**Sawubona...** Zulu... it means, 'I see you.' Not just... I'm looking... I see your soul..."

She would ask new hires to tell their story, then listen for the first moment they deviated from the "flow" of what life had already "agreed" for them.

That earliest divergence, she said, is the moment of individuation— "if you want to get kind of Jungian about it."

As they spoke, she would write down words, looking for the two that captured the essence of who they were. When she found them, people often cried.

"They would feel like they had just been seen... their story had been heard..."

"The greatest gift that one can be given," she said, "is the gift of being gotten."

Those two words became each employee's "BE words"—who they are being in the world—printed on the back of their business card, and even on personalized coffee mugs.

Clients noticed. It became culture made visible.

And then Judy connected it back to herself, why she keeps returning to "both/and."

People told her for years: "It's never either/or with you, it's always both/and."

"That is who I am," she said. "I am always looking for a way to embrace the both/and."

She laughed that the boardroom now calls her "the both-and woman"—both ALSAC and St. Jude, both research and care, both finding cures and saving children.

And she brought it to what she believes is St. Jude's "true north":

"It's about the kids," she said. "It's about saving a life... We are always present to the true north of the little kid getting pulled around in the wagon... it's about the child."

## "What's Possible"

Her advice to the younger generation came as three short imperatives:

**"Be present, know yourself, and make a difference."**

Before ending, she shared one last idea—something she says she has talked about often.

"Hope is a two-sided coin," she said. "**On one side of hope is fear. On the other side of hope is possibility.**"

When a family receives a diagnosis, hope is drenched in fear.

But then:

"When they cross the threshold of St. Jude, that fear... melts into possibility."

"St. Jude is about possibility," she said. "That is real."

She smiled at the personal echo: "The very first tagline of my company was, 'What's Possible.'"


WHO ARE YOU
BEING
IN THE WORLD...
AND HOW
GREAT
ARE YOU WILLING
TO HAVE IT?
OUR VISION
OUR MISSION
OUR VALUES

# Sustainability, the Architecture of Equitable Cancer Innovation

By Dario Trapani

In oncology today, innovation advances at a breathtaking pace, yet the capacity to deliver it to all who need it lags behind. Each new therapeutic frontier exposes the same paradox: the deeper our biological insight becomes, the wider the gulf between discovery and delivery. The question is no longer whether we can treat cancer more effectively, but whether the fruits of innovation will be distributed with fairness and foresight. As a clinician engaged in global oncology, I encounter this dilemma quite often, in the faces of patients whose prognosis depends not only on science but on systems. As a researcher, I see how access, affordability, and sustainability form the hidden architecture of modern oncology, a structure too fragile to support the weight of our progress unless we rethink its foundations.

## Mapping Inequality: The Geography of Access

The recent European Society for Medical Oncology (ESMO) **Global Survey on Access to Cancer Medicines**, the largest of its kind, offered a panoramic view of this imbalance. Conducted across 126 countries, it assessed formulary availability, out-of-pocket costs, and real accessibility of cancer medicines. The findings are empirical and ethical in their implications. In high-income settings, patients can generally access essential and innovative therapies without major financial strain. But in low- and middle-income countries (LMICs), 40% of basic chemotherapeutics listed byWorld Health Organization (WHO) as Essential Medicines remains available only at full cost to patients. Access to newer, high-value therapies, those with proven benefit according to **the ESMO-Magnitude of Clinical Benefit Scale (MCBS v2.0)**, is even more restricted – often, a privilege of selected high-income countries.

Such data draw a new **geography of global oncology**. They show that innovation has become a privilege of wealth, and that the correlation between a nation's income, the political commitment to strategize cancer care and the efforts toward value-based decisions and its citizens' chance of survival is as strong as ever. The survey's goal, however, was not to despair but to diagnose: to create a "Global Reference" that can guide public accountability, inspire equitable policy, and transform access from aspiration to measurable duty.

## Value as the Common Language of Sustainability

This brings us to the concept of value. Too often invoked, less commonly defined, value in oncology has become both a policy term and a moral compass. Value-based frameworks are not about restricting care but about restoring proportion, aligning the price of innovation with the magnitude of its clinical impact and the sustainability of the systems that must bear it. A value-based approach invites humility. It recognises that no therapy, however revolutionary, can be truly successful if it bankrupts the institutions meant to deliver it. It also demands intellectual courage: the willingness to question our assumptions about dose, duration, and necessity. This is where our work on dose optimisation and on defining new methodological approaches to the question of near-equivalent / more sustainable regimens become crucial. The principle is simple yet profound: if efficacy can be preserved at lower doses or shorter durations, access can expand without compromising outcomes. Rational use becomes an act of justice.

## A Case Study: The romise of Low-Dose Immunotherapy

Immune checkpoint inhibitors have transformed the therapeutic landscape, yet their price remains one of the major barriers to access, particularly in LMICs. To address this, a recent **systematic review** evaluated 32 studies exploring low-dose anti-PD-(L)1 regimens. The analysis revealed that, in selected settings, lower doses of nivolumab or pembrolizumab yielded encouraging radiological responses, sometimes comparable to standard dosing, while achieving cost savings exceeding 80%. These findings are preliminary, limited by heterogeneity, but they point to a rational frontier: a medicine that calibrates its intensity to its necessity. More robust data from the Indian randomized clinical trials in the space of **head-and-neck cancer** and the triple-negative breast cancer add scientific weight to this hypothesis, providing a new paradigm for cancer innovation: science-driven, evidence-based and sustainability-devoted. Both suggest that less may sometimes be enough, and that the optimisation of therapy can coexist with scientific rigour. Low-dose immunotherapy is not a shortcut but a question, a way of asking whether precision might also mean parsimony, and whether a smaller quantity of the same agent, properly validated, could democratise access globally. To turn such an approach from principle to praxis is, perhaps, the defining challenge of our time.

## Modelling Affordability: Collaboration and Shared Responsibility

The issue of price cannot be solved by clinical science alone. Economic modelling is its necessary counterpart.

*CSO session at ESMO Berlin, 2025.*

In collaboration with the Medicines Patent Pool (MPP), an organisation that has revolutionised access to HIV and hepatitis treatments through voluntary licensing and technology transfer, we explored the cost-effectiveness of immune-checkpoint inhibitors in PD-L1-high advanced non-small cell lung cancer across two LMICs: **India and South Africa**. Using a standard economic modelling approach, we found that to meet conventional cost-effectiveness thresholds (at 1-3× GDP [Gross Domestic Product] per capita, a common metric of cost-effectiveness definition), acquisition costs for these therapies would need to fall by as much as 93%. Yet this target, while ambitious, is not unprecedented. Comparable **reductions** have been achieved for monoclonal antibodies such as trastuzumab through the introduction of biosimilars and price-volume agreements. This analysis identified three synergistic levers: accelerated biosimilar uptake as they will emerge, dose and duration optimisation based on innovative methodologies, and voluntary licensing in eligible jurisdictions. Together, they can re-engineer the economics of access. This, ultimately, is what sustainability means in practice: not denial of innovation, but design of systems that make innovation endurable.

## The Moral Architecture of Access

The pursuit of access is not solely a technical or economic exercise; it is a philosophical esprit. What we define as "affordable" reflects what we value as a society. When a drug is priced beyond the reach of most patients, it is not only the market that has failed, but the moral imagination that sustains it.

Oncology as a whole must learn to think systemically, to integrate clinical, economic, and ethical dimensions into a coherent policy narrative. The **WHO Essential Medicines List** now includes several immunotherapies, signalling an institutional recognition of their transformative role. Yet inclusion alone is insufficient without mechanisms for sustainable provision, as outlined in the **recent WHO report on essential cancer medicines** and defined in WHO **guidelines** on pricing approaches for cancer medicines.

The integration of value-based health technology assessment, outcome-based reimbursement and other efficiency-oriented mechanisms, and real-world data registries can help create a dynamic equilibrium, where innovation is rewarded, but access remains universal. Such an approach requires coordination between regulators, payers, and clinicians, as part of international cooperation and solidarity.

## Common Sense as a Guiding Principle

The **Common-Sense Oncology** movement, of which I am a part since the very beginning, seeks precisely this equilibrium: an oncology that is intelligent in its innovation, prudent in its use of resources, and profoundly human in its intent. Common sense here does not mean simplicity; it means proportionality. It means resisting both the excess of nihilism and the excess of enthusiasm, reclaiming a medicine that is guided by evidence and empathy in equal measure. Sustainability, in this sense, is not a constraint on progress but its ethical refinement. To sustain something is not to limit it, but to carry it forward without collapse.

## From Vision to Implementation

The next frontier of global oncology will not be defined solely by the discovery of new molecules, but by our capacity to govern them wisely. Dose optimisation, biosimilar integration, economic modelling, and collaborative frameworks such as those developed by ESMO are not marginal details; they are the structural beams of a more just architecture.

If we can align evidence with equity, and value with vision, we will not only improve access; we will redefine what progress means.

The future of cancer care lies in a shared act of responsibility: between science and policy, innovation and prudence, the individual and the collective. To build that future, we must transform sustainability from a technical goal into a moral one. Only then will the promise of precision medicine become a universal right, not an accident of geography.

## About the Author

Dario Trapani is a medical oncologist from Milan, working at the intersection of clinical cancer care and global cancer control, inspired by people and committed to high-value medicine as a foundation for equity in oncology.

*CSO working group - core team, Kingston, Canada*

# Andrea R. Filippi

## Gentle with People. Precise with Cancer.

By Yeva Margaryan

Each evening, after a day leading one of Italy's busiest radiotherapy departments, Prof. Andrea Filippi, Head of the Radiation Oncology Unit at the Istituto Nazionale dei Tumori in Milan, and the Associate Professor of Radiation Oncology in the Department of Oncology at the University of Milan, walks from the cancer center to the station in Milan, earphones in, cello or piano in his ears.

"I listen to classical music while walking to the train," he says. "It's my way of distracting from the clinical part and all the issues of chairing a department."

Minimalist composers like Philip Glass and Wim Mertens keep him company on the commute back to Turin. It's a quiet ritual that hints at how he survives a job that demands emotional stamina, intellectual flexibility, and constant decision-making.

## From Architecture to Oncology

Medicine was not the obvious destiny.

"Until eighteen years old, I thought I would become an architect," he recalls. His father was an engineer, his mother had studied architecture; the path seemed set. Then a friend suggested he sit the medical school admission test "just to see."

"I tried the test for medical school, and I was admitted with one of the highest scores," he says. "My friend told me, 'You got this score; you need to do medicine.' So he convinced me."

The eye for structure, for space, for design never left. It simply shifted from buildings to bodies, from plans on paper to plans on treatment consoles.

## Stanford and the Realisation that Research and Care Can Be One

A summer at Stanford University changed not only how he saw radiotherapy, but how he saw the entire ecosystem around it.

"I saw a very different approach to patients," he says. "It was normal to enroll patients in clinical trials during routine clinic. Research and clinical activity were not separate at all."

"When I came back, I tried to find something similar," he says. "It changed my perception: I realised I could do research while seeing patients and offer them new approaches, not only standard care, but something more."

Back in Italy, working with mentors like Prof. Umberto Ricardi at the University of Turin, one of the first to introduce techniques such as stereotactic radiotherapy in Europe and Italy, especially focusing on lung cancer. Two decades later, he says, "What we now deliver in Europe and Milan is very similar to Houston, Stanford, or Boston."

Italy, once more a follower, especially on the technological side, has become a hub.

## "Less Is More": Bringing Fragile Patients into the Center

Filippi's most distinctive work has focused on patients who rarely sit at the center of clinical innovation: elderly, frail, comorbid people with lung cancer.

"**It happened to me to meet many fragile patients doing the lung cancer radiotherapy clinic in Turin at the start of my career,**" he says, "patients that most of the time are excluded from other clinical trials, and are also excluded from the standard of care because they cannot tolerate aggressive treatments, for example, concurrent chemo-radiation for an operable patient with stage III... They are often neglected, while they are willing to be treated with curative intent"

This philosophy went through the years, when he moved to Pavia in 2018 and then Milan in 2023, shaping the companion phase 2 trials **DUART** and **DEDALUS**. "We were driven by the idea that less is more," he explains.

**DUART** tested radiotherapy plus immunotherapy, without chemotherapy, in very elderly or comorbid patients with unresectable lung cancer, some treated at doses traditionally considered palliative. The result: overall survival doubled compared with radiotherapy alone, with low severe toxicity.

One finding moved him deeply: "**Elderly and fragile patients want to be included in clinical trials... I never heard a patient say, 'I'm not interested**.' They want to get the best available treatment."

**DEDALUS** explored an induction phase with chemo-immunotherapy followed by reduced-dose radiotherapy.

"They are companion trials," he says, "because the focus is on de-escalating treatment while maintaining efficacy and improving quality of life."

## The Future Topology of Radiotherapy

For Prof. Filippi, radiotherapy's next evolution is defined by precision, not expansion. "We are moving away from very large fields and extensive prophylactic irradiation. Instead, we're treating only primary tumors and involved nodes, through advanced image-guidance and hypofractionation."

What will unlock the next leap, he believes, is the convergence with nuclear medicine. "Molecular imaging and radioligands are moving very fast. With cancer-specific tracers and PET-guided treatment, we can target metastases that light up because we're using the right tracer. This will transform the field."

Improved imaging allows for more targeted treatment. "You don't need to be aggressive with radiation volumes and doses like before. You can be more precise, using radiation as a non-invasive, intelligent drug that you can deliver locally, adjusting the dose and volumes for each patient."

## Immunotherapy and Radiotherapy: A New Space of Combinations

His energy brightens when discussing systemic therapy. "There is enormous potential in combining many classes of immunomodulators with radiation therapy," he says. First checkpoint inhibitors were a revolution, but only the beginning.

Oncology, he argues, is entering "a new revolution" driven by bispecific and trispecific antibodies and T-cell engagers for solid tumours, CAR-T cells, vaccines, agents far more refined than early immunotherapies. But he is clear-eyed: "We don't know what will be the ideal combination... we need to wait."

Still, he works with companies to explore radiation-drug combinations through nimble, focused trials. "They don't need to be huge clinical trials; we need to find the best combination for single indications in smaller cohorts, and if the first findings are clearly promising, we can move forward with larger trials."

Early signals are compelling. In different cancers, such as lung or head and neck, bispecific dual checkpoint inhibitors such as anti-PD(L1) + anti-TIGIT or anti-CTLA-4 (with many others under development) administered after RT showed promising effects, enhancing the immune response and, hopefully, also leading to dose reduction, as the synergy between radiation and the immune system might be optimized and allow for de-escalation.

The challenge now is not only about ideas but also about building a platform for the radiation-drug development. "We have so many classes of new drugs, so many possible combinations, that you need a disease-specific, rational strategy focused on unmet needs." Academic–industry partnership, he says, is essential: "Ninety percent of oncology research is driven by industry. We need to work together, and convince them to explore new combinations. That's why we created inside ESTRO, the European Society for Radiation Oncology, a focus group dedicated to new radiotherapy-drug combinations, that I have the honor and pleasure to coordinate starting next year."

## AI in the Department: Faster, Smarter, but Not in Charge

Artificial intelligence is not something Prof. Filippi approaches with hesitation. Instead, he sees it as an accelerating force that will subtly, but decisively, reshape the daily mechanics of radiotherapy. In his view, the coming years will bring a quieter revolution inside treatment rooms, planning consoles, and tumour boards.

He imagines a workflow where many of today's bottlenecks dissolve.

"AI will probably fasten and standardize the patient flow to the Radiation Oncology Department," he says.

He envisions a workflow where automated contouring swiftly identifies targets, and machine-learning tools create treatment plans with significantly less manual effort. Delivery, whether through protons or photons, will become "very focused and able to dynamically target the tumors and to spare a lot of surrounding healthy organs."

The integration of imaging and **AI will revolutionize** how we deliver radiation, but the fundamental principle remains unchanged. The main goal continues to be destroying cancer cells or modifying the microenvironment to improve the efficacy of systemic agents.

Radiation oncology, he argues, is utilizing only 5-10% of AI's potential. The frontier lies in decision-making: determining who needs a specific combination, in what sequence, and when. "We need a deep understanding of what AI agents will tell us, and probably we need to be trained on how to use them, but this is a significant issue for the entire field of medicine, not just Radiation Oncology."

He sees AI as an assistant, never the lead clinician.

"It's a co-pilot. It's AI working with humans to change how we practice oncology and conduct research." He is especially interested **in virtual clinical trials,** where AI creates a real-world control group for comparison. "At the end, you're treating your experimental arm A, and you're comparing it with a virtual control arm B... 100% of your patients will receive the new drug... it's one of the many exciting innovations we hope to see soon," he said.

## Leadership as Dialogue

As the department head, he describes leadership as one of the most challenging and rewarding responsibilities. He states, "I love mentoring young oncologists. I am also an associate professor at the Oncology Department of the University of Milan, but you need to listen to more experienced colleagues too, and balance the team; it's not easy"

Mentorship, in his view, is reciprocal. "The dialogue between different generations is beneficial because you learn a lot... You are not simply transferring knowledge from the older to the younger. In the end, you achieve something more. It's a continuous dialogue."

Clinical cases, he says, are the best shared language. "I try to make all my medical staff comfortable in discussing cases, and just knocking at the door if they have doubts... Oncology is becoming very difficult, and super-specialized: we all work in multidisciplinary teams dedicated to a single tumor entity, but sometimes there are specific issues related to your field, in my case radiotherapy, that may require complex answers."

He encourages young colleagues to bring embryonic ideas. "Let's write it down and think about it. Every idea is good in principle; then I can help find weaknesses and move it forward."

What he refuses to accept is the culture of constant publication as an end in itself.

"In my opinion, excellence is not based on a competition between researchers over the number or frequency of publications; we all know that real progress needs constant effort, long times, discussing, rethinking, and then ending up in important clinical trials or translational research programs. This makes the quality and matters to science and patients: then all metrics will follow," he says.

At the start of a career, he advises them, "Don't think about publishing soon, but focus on pursuing the right project, working with scientists you trust most, traveling, seeking dialogue, creating networks, enjoying yourself, and then high-profile projects and publications will come."

Clinical research, he adds, is also about timing and luck. "Sometimes a trial goes the right way, and it starts something new, sometimes not, but if they are of quality, they always help in moving forward."

## We Need a Global Strategy

When he speaks about global cancer care, his tone sharpens. The world is innovating rapidly, but unevenly. "We are talking about wonderful progress in the Western world and Asia... but half the world is completely out of that. It's unfair."

Real change, he argues, requires political commitment. Screening programs, infrastructures, HPV vaccination, and tobacco control cannot be delivered without international leadership. "I would put oncology among the top issues at the global political level."

True progress relies on two key partnerships: industry–academia collaboration and patient-advocacy involvement. "For sure, it will be positive," he says of deeper alignment. "Our job is to collaborate in designing a global strategy."

## The Blitz Round: Who is Prof. Andrea Filippi?

***A quote you live by?***
*"The true elegance is simply to be gentle with people."*

***Favourite book and movie?***
*Here, his Italian roots surface effortlessly. His favourite book is Ferito a Morte, Raffaele La Capria's atmospheric novel of Naples, "a wonderful book," and his favourite film is La Dolce Vita, Fellini's iconic meditation on modern Italy.*

***A quality you most value in colleagues?***
*"Humour," he says without hesitation.*

***The biggest myth about radiotherapy you'd like to dispel?***
*"That radiotherapy is more toxic than other treatments. Probably because we have the word radiation," he says. "Even after thirty years of progress, colleagues still talk as if it's more dangerous, when chemo or immunotherapy also have many complications.You just need to have good knowledge and clinical skills, interdisciplinary collaboration, and you can manage many side effects and deliver radiation in a very safe way."*

***If not a doctor, what would you be?***
*He smiles. "An architect."*

***Three words that describe you best?***
*"Gentle, creative... and I admit being a little bit absent-minded sometimes."*

**Best piece of advice you ever received?**
*"To try to be courageous in medicine and sometimes take a little bit of risk to reach the best."*

***Most inspiring people you have met in oncology?***
*He names two: Prof. Corrado Tarella, the haematologist from the University of Turin who taught him "how to imagine new solutions for patients when the guidelines don't tell you anything," and Roberto Orecchia, scientific director of the European Institute of Oncology in Milan"a radiation oncologist who has a great vision, placing radiation therapy in the right context and looking at what happens around."*

***One thing people would be surprised to learn about you?***
*"I read a lot of poetry, and I'm also very interested in philosophy."* It sounds far from medicine, he admits, but for him, it isn't.

Prof. Andrea Filippi's work steadily pushes radiotherapy toward a future that is lighter, more precise, and more inclusive of those who have been left at the margins.

He could have become an architect of buildings. Instead, he became an architect of care, designing treatments where, as he puts it, "less is more," and where "you can be gentle in treatment, just as you can be gentle with people."

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# Hosams Abu Meri

# From Mountain Village in Lebanon to the Heart of Latvian Health Reform

By Gevorg Tamamyan

When Dr. Hosams Abu Meri walks into a clinic room in Latvia, patients see something very unusual. The person doing their gastroscopy or colonoscopy is not only a gastroenterologist, he is also the Minister of Health of the Republic of Latvia.

He still gets selfies in the endoscopy room. Patients apologize for asking, then say what many of them feel:

“I trust you more. When you explain my diagnosis in one sentence, I already feel healthier.”

His story is not a simple one of career change from medicine to politics. It is a story of family, migration, responsibility and dual loyalty, to his patients and to his adopted country.

## Born Into Medicine, Born into Politics

Hosams Abu Meri likes to say that both of his professions started in childhood.

He grew up in a village in the mountains of Lebanon, in a large extended family.

“I was born in a family of doctors, a lot of doctors. Two of my uncles are doctors, my friends, my cousins. When we met in summer at lunch or dinner there were always three or four doctors at the table. So, it is something like genetics.”

Medicine was one side of the family tradition. The other side was politics and public service at the local government level.

Half of the village shared the surname Abu Meri. His grandfather and relatives often chaired the local council or sat on it, led municipal campaigns, organized candidate lists, and wrote programs for each four-year cycle.

“I saw my grandfather holding meetings at home, preparing lists, planning for the village. That stayed in my mind. Maybe that is why I wanted to be a politician one day, although I never imagined it would be in Latvia.”

## Choosing Gastroenterology, A Whole System from Mouth to "Canalization"

He finished medical school in 1999 and faced the classic residency decision.

"I had to choose between internal medicine specialties. I was thinking about cardiology and gastroenterology. I was also calculating the risks and workload of each profession."

Cardiology attracted him. Yet the complexity and continuity of the digestive system drew him even more.

"Gastroenterology is a huge system. It starts from the mouth and ends, as I joke sometimes, in the canalization of the body. You can diagnose and treat with endoscopy. That is very challenging for me."

Endoscopy gave him exactly what he wanted: a mix of diagnostics and active intervention.

## From Lebanese Village Politics to Latvian Parliament

His path into politics did not start from a party office. It began with community work and identity.

After the 9/11 attacks and the rise of Islamophobia and Arabophobia, he felt a responsibility to explain the Middle East and Arab culture to Latvian society.

He founded the Lebanese Cultural Society in Latvia, then the Arabic Culture Center, and became a frequent commentator in the media on the Middle East, the Arab Spring, and regional conflicts.

At the same time, he learned Latvian, worked as a physician, and built trust in his local community.

"All this together, plus being a doctor and speaking Latvian, gave me a certain popularity."

He obtained Latvian citizenship in 2007. Friends in politics soon approached him as they were forming a new Unity party, bringing together three parties with a centre right ideology.

"I liked their idea. Around 2009–2010 I started my political career in Latvia."

The boy who grew up watching his grandfather write local programs in Lebanon was now shaping policy in a Northern European state, as an MP and later as Minister of Health.

## A Bridge Between Latvia and the Arab World

His background gives him not only a personal story, but also a strategic advantage.

"Arabic is an additional language I can use here. It allows me to speak directly with ministers of health and politicians from the Arab world and to use contacts across the region." He points out that the Lebanese diaspora is spread across the Middle East, Europe, the Americas and beyond.

"You always have someone, a friend or relative, somewhere. You can always find a contact to help the mission I am doing right now."

This is not theoretical. He recently visited Egypt and toured three major pharmaceutical manufacturers.

"I am looking at Egyptian production as effective and cheaper than many European products. If we can bring lower cost but effective medicines to Latvia, especially for expensive treatments like hepatitis C or biological agents, we can help our people."

These ties also help raise Latvia's profile outside the European Union, where the Baltic states are less well known.

"In Europe everyone in politics knows Latvia and the Baltics. Outside the EU you first have to explain where Latvia is, our population, borders, the situation in Ukraine. These connections help us get to real cooperation faster."

## A Minister Who Still Does Endoscopy on Saturdays

Unlike many ministers who leave practice entirely, Dr. Abu Meri still sees patients regularly.

"On Friday morning I had two hours of consultations. On Saturday I worked the whole day and did 19 endoscopic procedures, colonoscopies and gastroscopies."

Patients are often surprised to discover that the person treating their gastritis or performing their colonoscopy is the minister himself.

"I get a lot of selfies in the clinic. People say, 'A gastroenterologist and the Minister of Health, I am proud to meet you.'"

For him, continuing to practice serves two purposes.

First, clinical quality:

"I must keep my skills. I am a doctor."

Second, direct feedback on policies:

"As a doctor and politician, I feel the direct consequences of my decisions. When a patient sits in front of me and tells me how they feel after a reform, after one or two years, I am not far from reality. This is very important."

## "Smile and Keep Hope for the Patient"

Asked about the most important trait for a doctor, he does not hesitate.

"Fifty percent of a medical doctor's job is communication."

He insists that explanations must be clear, calm, and in normal language.

"You must let the patient feel comfortable, not push or press them, and build trust. When you explain what they have to do in a comprehensive way, many patients leave already feeling better."

He tells the story of a couple who drove 60 kilometers from Riga to find him after three years.

They had seen other gastroenterologists and respected them, but insisted on seeing him again.

"The wife told me, 'When you tell me one sentence about my diagnosis and the tablets, I immediately feel healthy. Thank you that you are still practicing.' She needed five minutes. I repeated what she has to take and when to return. For her, this was enough."

Even on the most exhausting days, he insists on kindness and composure.

"Sometimes you are tired, you feel sick yourself, but you must still smile and keep hope for the patient."

## The Weight of the White Coat, Burnout and Workforce Shortage

He is candid about the pressure doctors face, and he speaks from experience.

"I had a lot of hours, like everyone in Latvia now. We have a problem with human resources, a shortage of doctors, nurses and assistants."

Doctors compensate by working extra shifts and long days. "There were days I had 20 or 25 consultations and no time to eat. Imagine, a gastroenterologist who does not have regular meals, while telling all patients to have regular meals."
Burnout shows up in complaints.

"85% of all complaints to our health inspectorate are about communication. Not because doctors are bad people, but because they are exhausted, physically and mentally."

He recalls nights when difficult cases followed him home.

"You go to bed but wake up in the middle of the night, thinking of a patient. You take books, you search online for answers to unclear diagnoses. It is a very stressful job."

Yet, he admits something surprising.

"Compared to the job of a minister, the job of a physician was better. As a doctor you feel positive reactions quickly. As a minister, you work 24/7 and the impact is slower and less visible at the moment."

## Why Latvia Lost Health Workers and How It Is Rebuilding

He traces Latvia's workforce crisis back to the 2009–2010 economic crisis.

Budget cuts hit health care, hospital networks were reorganized, and the medical sector was not a political priority. Salaries were low, and many doctors and nurses left for other EU countries.

"We estimate that about 300,000 people left Latvia in the last 10 to 15 years. Now maybe 25,000–30,000 are coming back."

At that time, there was also insufficient state support for medical education and residency. Many trainees had to pay for their own specialization or rely on a hospital sponsor.

The situation today is different.

Over the last decade, Latvia has increased public funding for health from around 8**00 million euros to almost 2 billion euros**.

Residents' salaries have risen from **700–800 euro**s to almost **2000 euros**, and they can earn more by taking on duties in different institutions.

Doctor salaries are now close to EU averages for those who work the many hours available. The bigger gap is in nurses' pay and numbers, which the ministry is trying to address with better salaries, working conditions, insurance and bonuses.

"We need five to seven years to really feel the effect. We are also redesigning the hospital network and making education more flexible, for example allowing specialists to learn additional procedures in parallel, updating credit systems, and reducing unnecessary bureaucracy in partnership with professional associations."

## The Abu Meri Plan, Cheaper Medicines and a Digital Health System

When he became Minister of Health, he sat at home one night with a pen and a small napkin and drew what he calls the "**Abu Meri plan**" for the health system.

"I needed a strategy from day one, short term and long term."

His short-term priority was very concrete: **reduce medicine prices**.

At that time, wholesalers received a percentage margin on every package, which he considered excessive.

"We fought for one and a half years with the wholesalers. It was a very tough fight."

From 1 January this year, a new pricing system came into force.

- Prices of about **70%** of medicines decreased by **15–20%**
- Some dropped by 50%, for example a migraine drug that fell from 33 euros to about 15 euros

He also **redefined the role of pharmacists.**

"I do not want pharmacists to be just sellers. They study five years at university. They must become part of the treatment team."

Now, for each prescription, the pharmacist receives a small fixed payment, shared between the state and the patient. In return, they are expected to counsel patients on how to take the medicines, interactions, and side effects.

On the long-term side, his focus is **digitalization**.

- The e-health system has been technically improved
- A new Laboratory Model now allows patients to see lab results for free in e-health
- From November, e-referrals have started, and e-booking will follow, to cut waiting times by 15–20%
- A Health Digital Center has been created to coordinate these efforts

Methodological centers have also been established, including in oncology and rehabilitation, to develop guidelines, monitor quality of care and calculate realistic costs of services.

Latvia is also piloting "**hospital at home**" services for chronic conditions like lung and heart disease, using digital monitoring to keep patients at home rather than repeatedly admitting them.

Primary care is being strengthened, with **more funds for family doctors** and additional incentives for those willing to work in **rural and remote areas**.

"You cannot move forward if you work on only one level. You must move in parallel."

## Cancer in Latvia, Progress and Persistent Gaps

Oncology is both a professional and political priority for Dr. Hosams Abu Meri.

Recent years have brought pilot projects with increased funding for reimbursement of cancer medicines, particularly for innovative breast cancer treatments, and a stronger push on screening.

He notes an improvement of around **27% in 5-year**

**survival** in some groups, including stage IV patients, after better access to therapies and more timely diagnosis.

Screening coverage is rising from very low baselines:

- Cervical cancer screening participation is now above **50%**
- Breast cancer screening has increased to about **38–40%**, up from **15–20%** a few years ago
- Colorectal cancer screening has risen from around **15% to 27–28%**

A digital mammography bus travels through rural areas so that women who cannot easily reach hospitals can still get mammograms.

The HPV vaccine is now funded by the state up to age 24, for both boys and girls, to reduce future cervical cancer risk.

However, Latvia still lags the EU average of 70% screening participation.

A major weakness has been data.

"When you compare Latvia with EU countries, we are often at the bottom of the list in incidence and mortality statistics. But I feel that part of this is lack of data, not just bad outcomes."

A national screening registry and platform is now being built so that participation, diagnoses and outcomes can be tracked in detail and analyzed.

Cancer funding for medicines has increased from **50 million to almost 80 million euros**, and the total reimbursement budget has grown from **220 million to 320 million euros** in two years.

"I cannot show all the results today. But I am sure that in two years we will see important impact on mortality and survival."

## Tobacco, Vaping, Alcohol, Obesity, A Public Health Frontline

He sees cancer not only as a matter of treatment, but as the result of behaviors and environments that must be addressed together.

As an MP in 2023, he worked on amendments to the tobacco and nicotine law.

From August 2024 and fully from January 2025, Latvia has:

- Banned flavored e cigarettes and vapes
- Prohibited advertising of such products
- Raised the legal age for purchasing and using tobacco products from 18 to 20 years
- Set a limit of 4 mg of nicotine in nicotine pouches, down from previous much higher levels

The aim is to protect children and young people, whose vaping rates climbed sharply during the COVID years, with nearly half of pupils having tried cigarettes or flavored vapes at least once.

Industry has responded by creating flavor drops and other workarounds, so new challenges keep emerging.

Latvia has also raised excise taxes on tobacco and alcohol and passed stricter laws on alcohol advertising and sales hours, particularly around holidays, to reduce harmful use.

"We are among the highest in the EU in alcohol consumption, around 11.7 litres per person. Alcohol is a major cause of pancreatic, colon, liver and other cancers, as well as cardiovascular disease."

Obesity and low physical activity are additional priorities. Recent government plans on obesity and a new oncology plan were adopted by the Cabinet, and he stresses that all these issues, from tobacco and alcohol to inactivity and obesity, must be fought together.

## Europe as One Health Space

When he talks about the European Union, he speaks about **health as a shared responsibility**.

"We live in one region and one space as one whole area. We should be united, especially in health."

For him, that means:

- A unified EU policy on tobacco and nicotine, including stricter directives on flavors and e cigarettes
- Common approaches to obesity, addiction, non-communicable diseases, and preparedness for infectious threats

He argues that if member states adopt regulations that are not matched at the EU level, illicit trade and cross border purchases will undermine national efforts.

“If I have a law that I cannot implement 100%, it will not work well. We need European solutions for European problems.”

## Mentors, Books and Continuous Learning

Dr. Hosams Abu Meri does not name a single mentor. He has many.

He often meets former presidents of Latvia, including **Vaira Vīķe Freiberga**, whom he deeply admires.

“She is a politician who has done a lot for Latvia, with a brilliant mind and wide cultural experience. Sitting with her for a few hours, you learn a lot.”

He also seeks advice from senior economists, journalists, professors from different sectors, and even younger colleagues.

Inside the ministry, he considers his own team a source of learning, from advisors on law and communication to technical experts.

“They tell me what is possible and how to implement ideas. You must be ready to learn from everyone around you.”

His reading time has shrunk dramatically in the last two years, but one book stayed with him, a large work by former US Vice President Al Gore on climate change, the economy and politics.

“It showed me the scale of global challenges, especially climate change. It made me think, what will the world look like in 100 years and what can I do today to help change the course.”

He also likes small handbooks from airport bookshops, short reflections on life, stress, friendship and daily behavior that can be read in one flight.

## Two Messages for the Next Generation

His advice to young people is simple and firm.

**First, guard your health.**

“Health is not something you just receive at birth and then ignore. It is everything for you. You must take responsibility for your sleep, physical activity, food and nervous system from the very beginning.”

**Second, do not be afraid of big dreams.**

“Any dream you have in childhood, any goal you want to reach, is possible. But you must be patient, work hard, and not get angry when you fail. Stand up again, try again and again. You will reach your goal.”

## How He Sees Himself, and Who He Thinks You Should Talk to Next

Asked to describe himself in one sentence, he answers quietly:

“I am a person who has devoted himself to the benefit of the people I live with.”

He acknowledges that not everyone agrees with his decisions and that some letters he receives are harsh or insulting.

“But it means I am doing something. If nobody reacts, it means you do nothing.”

As for who should be interviewed next, his choice is personal.

He recommends **Ivars Godmanis**, former Prime Minister of Latvia, who led the government in the early 1990s when Latvia regained independence and again during the 2008–2009 crisis, and who is also a professor of economics and former Member of the European Parliament.

“To talk with him is a pleasure. You always learn something new. Even now he sometimes calls me and says, ‘You gave an interview, I did not like that answer, you should say it like this.’ He is a very dear mentor for me.”

From a mountain village in Lebanon, in a family of doctors and local leaders, to Riga, where he now balances an endoscope in one hand and a health system strategy in the other, Dr. Hosams Abu Meri has built a life at the intersection of medicine, politics and identity.

He calls it simply **service.**

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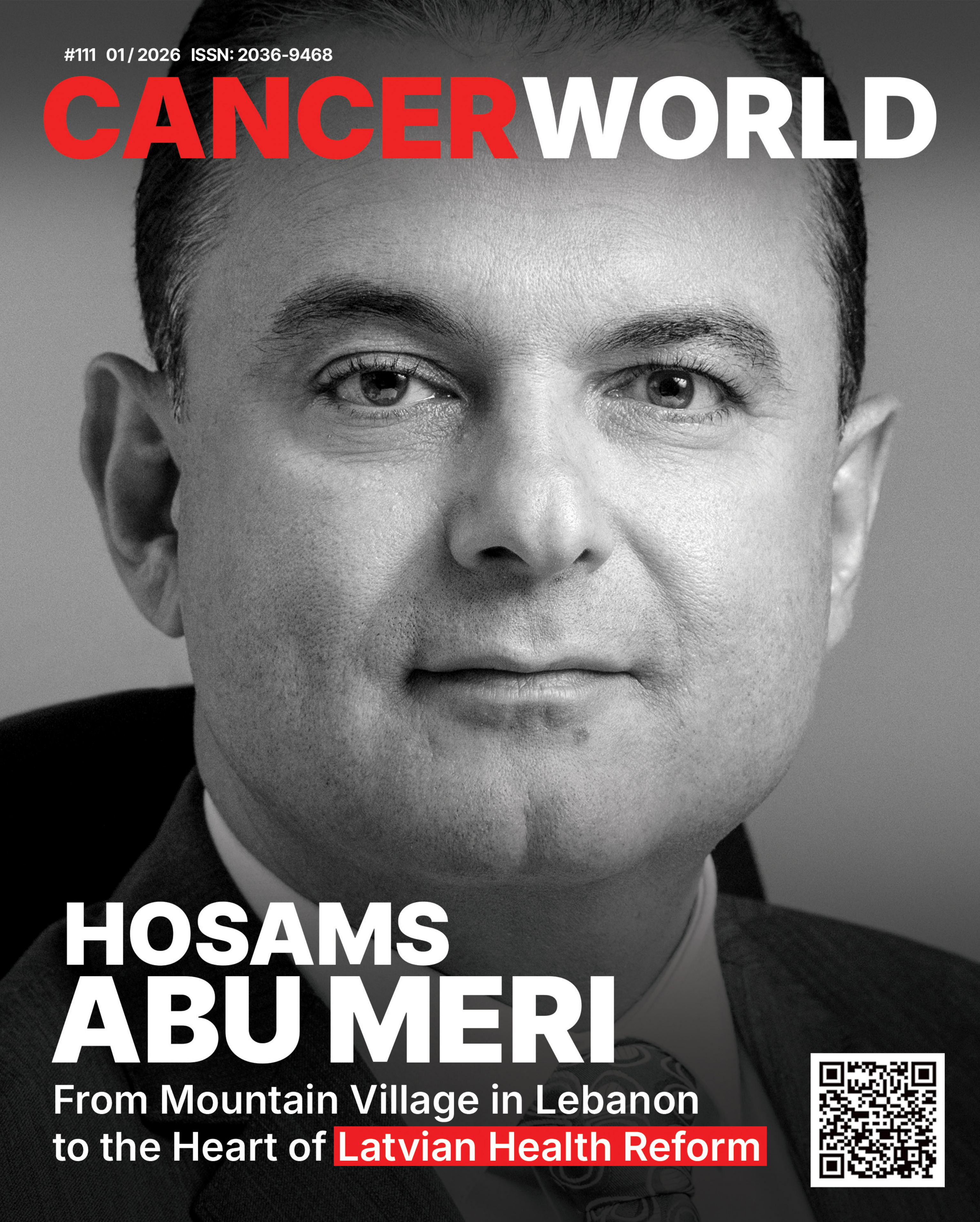
# CANCERWORLD



## HOSAMS ABU MERI

From Mountain Village in Lebanon to the Heart of Latvian Health Reform

> I must keep my skills. I am a doctor.

# Between Two Worlds

## The Quiet Resolve of Ingrid Krücken

By Yeva Margaryan

I met **Ingrid Krücken** in the quiet frame of a video call. As she talked about her childhood in Madagascar, her teenage years in Germany, and the years that followed, full of changes, challenges, and unexpected turns, it became clear how much her life has shifted from one world to another.

Each change pushed her to adapt. And over time, those experiences shaped her into someone who learned to fight for herself when she needed it most, and then turned that strength outward, to fight for others.

This is her story.

## A Childhood of Warmth, and a Sudden Exile

Ingrid grew up in Madagascar, in a world defined by closeness. There were always cousins around, always grandparents a short walk away, always neighbours who felt like extended family. She describes her childhood as protected, full of laughter, woven together by community and cultural warmth.

Her father, a German engineer in the textile industry who worked on a volunteering project on solar cookers to fight deforestation in Madagascar, would bring her along on visits to remote villages where solar panels were assembled.

“My father taught me you cannot only take, you must give back to society.”

That message rooted itself quietly in her. But at thirteen, her life was abruptly divided. Her father decided she needed to attend a German school in Germany, not the French school she preferred. Overnight, she lost everything familiar.

“I had the feeling I lost my friends, I lost my environment. The two countries are very, very different.” She laughs…

Yet, she admits: “It made me independent. It made me resilient. In Madagascar, you are overprotected. In Germany, you must stand alone.”

She could not know then that this early forced resilience would later become the backbone of how she navigated illness, and why she fights for patients who feel unmoored.

## “How Do I Tell My Daughter?”, the Day Her World Tilted

In July 2021, long before any official imaging, Ingrid already sensed something was wrong. She saw her doctor immediately. When she received the diagnosis, **DCIS**, a very early-stage breast cancer, she was the first in her family ever to hear the words ‘you have cancer’.

What she remembers most is not the shock. It was the dread of a single question:

“How am I going to tell my daughter? She was eight years old.”

Her doctor reassured her, excellent prognosis, tiny tumour, early detection. Strangely, she felt almost relieved because her intuition had been validated.

But the diagnosis also exposed a second reality: **cancer isolates**.

“There is a stigma around it. You know it exists, but living it is very different.”

## The Doctor Who Set the Standard of Communication

After her first surgery, Ingrid told her daughter. They talked each other.

Then, **one and a half days later**, the hospital called. Something had been underestimated. There might be an invasive component. More treatment would be needed. It felt like the ground dropped.

Her surgeon, Dr Jean-Baptiste Olivier, sensed her greatest fear: not cancer itself, but her daughter’s reaction to it. So he made an unusual offer:

**“He said, ‘I will meet your daughter and explain everything.’”**

He set aside 30 minutes, an eternity in clinical time. He spoke directly to her daughter about reconstruction, about implants, about what surgery meant. When the girl, thinking like a child, asked:

**“My mom does a lot of sports, what if the implant explodes?”**

He didn’t dismiss her worry. Instead, he turned it into empowerment. He took an implant, handed it to her, and said: “**Throw it at the wall.**”

She did. It bounced. He explained robustness, material, safety, in a way an eight-year-old could understand.

Then came her hardest question: “**Why did the cancer**

**come back if they already removed it?**"

He explained micro-cells, invisibility, biology, uncertainty, in clear but scientific language.

"She reacted in a way I didn't expect. She said: *Okay, I'm fine with it*. Because she had the opportunity to speak."

That moment became, for Ingrid, the perfect example of what humane medicine looks like.

And also how rare it is.

*Ingrid and her daughter.*

## I Felt Like a Cancer Criminal

If her doctors gave her humanity, the system gave her the opposite. The worst emotional blows did not come from treatment, but from bureaucracy, particularly the **National Health Insurance**.

She describes being treated with suspicion, as though needing sick leave were a moral failure rather than a medical necessity. "I felt really disrespected... like a cancer criminal."

Patients undergoing chemotherapy often need months away from work. Yet they must repeatedly justify their absence, over and over, as if they were doing something wrong.

And then came the moment that broke her. Travel during sick leave requires official approval, even for visiting family. Her first request, shortly after diagnosis, was denied.

"I was devastated. I told my husband: "go without me". I didn't want to ruin my daughter's vacation."

Later, in the insurance office, overwhelmed by frustration and anger she completely lost it.

"I said: If you had cancer tomorrow, would you talk to me like this?"

She laughs and said: "I worried the official might call security But even through anger, Ingrid held her ground:

"Even if you cut all my indemnities, I will tell the truth. This is not acceptable."

That moment shaped her future role: she would fight for every patient who ever felt small in front of authority.

## Knowledge as Light, Networks as Lifelines

When asked where she finds strength, Ingrid doesn't speak in metaphors. She speaks in tools.

**Knowledge**, she says, is power.

"If you want information from a doctor, you need to ask the right questions. Knowledge is super important."

Not everyone is like her, insistent, questioning, unafraid to "harass" doctors for information. Many patients resemble her mother, who simply follows doctor's orders. For them, advocates become translators, guides, interpreters of medical language. To talk to pharma or doctors properly, we need high health literacy."

The second source of strength is **peer networks**:

"You don't feel isolated if you have peers. They know exactly what you've been through, and it is sometimes easier to share intimate matters with fellow cancer survivors... there is no taboo...

Cancer survivors recognise each other , she adds. They recognise what the world looks like after the ground moves.

## The Role of Europa Donna

In Luxembourg's small but growing advocacy environment, Ingrid initially had to design her own path, her own methods. But within Europa Donna, a coalition of 47 countries, she found a network of women whose experiences broadened her worldview: advocates from Slovakia, Italy, Greece, Slovenia, Turkey, each facing different national realities, each adapting in their own way.

I could have joined a national organisation but I preferred the European nature of the coalition.

I will always be a committed Europhile and a strong believer in the European project. That's by the way the reason why I had decided to do a master in European law.

"Almost all women I have met at Europa Donna are my mentors in a way."

Among public figures, she speaks of **EU Commissioner Stella Kyriakides** with particular admiration:

"She is genuinely empathetic and politically engaged, you don't often have both."

## Equity and Justice

When the stakes are high, Ingrid returns to the same values:

"Equity and justice. Even if it's small steps, you have to keep going."

For her, justice in cancer care includes:

- **Access to innovative drugs**
- **Equity between countries**
- **Equity within countries**
- **Survivorship support**
- **Right to be forgotten protections**
- **Freedom from financial hardship**

She recounts a Europa Donna board member from Slovakia saying that if she had metastatic cancer, she would not be able to afford life-extending treatments, unless she were wealthy.

"We're not talking about a low income country, we're talking about Europe."

Even within countries, she notes disparities: patients in remote villages do not access the same care or information as those in major cities.

## Start With Survivorship

Despite advances in drug development, one part of the patient experience remains chronically neglected: **survivorship**.

"Patients are lost. They don't know where to go when side effects appear. And side effects affect adherence."

Supportive care, physical, psychological, financial, social, is often not integrated into treatment pathways.

She also fights for return-to-work protection, noting that many companies sign the "Working with Cancer PledgeMovement" publicly but fail to support employees in practice.

And she works on the "**right to be forgotten**", to end the decade-long financial penalty survivors face in insurance and mortgages.

Her legal expertise comes alive in structural reforms. She was part of the first Luxembourg project where patients co-designed clinical trial documents from the beginning.

She was also part of a national d**iagnosis-announcement toolkit** after a national survey describing the traumatic experiences of the way their diagnosis was announced.: "If the announcement is not great, you carry that experience throughout your journey."

Ethics, dignity and empowerment of patients: that's why she joined the national committee on ethics in research.
Her core principle: collaboration over competition.

"We must not work in silos. We all want the same thing."

## Supporting Families in Crisis

Among all her achievements, **The Luxembourg Family Project** is closest to her heart.

It began with calls from overwhelmed parents undergoing treatment while raising young children. In three months, the team launched a program offering babysitting, house cleaning and transport for children's activities. I am particularly proud that our small team of fierce ladies of Europa Donna Luxembourg initiated this idea. But the implementation of the project would not have been possible without the collaboration of the Luxembourg

*Ingrid's favourite beach in Madagascar.*

Cancer Foundation and Arcus asbl, an organization which provides childcare services. This is an example that collaboration between patient associations and multiple stakeholders is key to serve the patient's needs.

"These are things you cannot do when you have chemotherapy... You want your children to have a normal day-to-day life."

It is now in high demand, and sustaining it long-term requires government support.

## Who Is Ingrid Krücken?

She is a woman shaped by intensity and softness:

- She dances to replenish her energy.She loves books about identity and resilience, Jane Eyre by Charlotte Brontee, In the name of Identity by Amin Maalouf. I truly believe in the sentence that identity lies not in one's place of origin, but the history that has formed you and in the path that one has traveled... that's why she loves travelling
- She admires Maya Angelou, Marie Curie.
- She lost her filter after cancer and embraced honesty.
- She had to make a crucial decision for her health after asking Prof Curigliano for a second opinion a few days before the actual start of her chemotherapy. She will always be grateful for his time and dedication. Protocols sometimes need to be adapted to the patient. This shows how important personalized medicine is...
- She laughs easily, especially at human quirks and contradictions.

From her own experience and the experience of patients, What she wishes people wouldn't do: Cancer ghosting due to fear and awkwardness., because people sometimes struggle with their own mortality. When I asked her what her North Star is, she didn't hesitate: "Equity. Justice. Empathy."

Her story is not one of grand gestures. It is the story of a woman who was uprooted at thirteen, diagnosed at the height of her professional life, confronted by bureaucracy at her most vulnerable, and who decided, quietly but firmly, that she would help reshape the system for those who come after her.

If her life had a title, it might be:

"**Between Worlds and Building Bridges.**"

Because that is what she has always done. And what she continues to do.

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# Jan van Meerbeeck

## Screening isn't Just Evidence, It's Equity

By Sergey Badalyan

When I signed into the call with Prof. **Jan P. van Meerbeeck**, I expected an interview about lung cancer screening, emerging biomarkers, and the frustrating gap between evidence and implementation. What I didn't expect was how *light* the conversation would feel, despite a career spent alongside diseases that rarely offer easy endings.

Van Meerbeeck has the calm of someone who has learned to pace himself over decades: attentive, direct, generous with context, and quietly funny in a way that makes you lean in rather than laugh out loud. He is also, by any measure, one of Europe's defining thoracic oncology figures, trained in internal medicine and pulmonology, shaped by practice and research across Belgium and the Netherlands, and deeply engaged in European networks where policy meets clinic.

He speaks about "revolutions" in lung cancer care, but without triumphalism. He's proud of progress, yes, CT and PET-CT transforming staging, platinum chemotherapy becoming evidence-based standard care, targeted therapy arriving in the early 2000s, and immunotherapy changing the landscape again. Yet he keeps returning to the same question: *what does this mean for real people, in real health systems, at real scale?*

That tension, between what's scientifically possible and what's practically deliverable, threads through everything he has done: clinical trials, European guideline work, health technology assessment, and his long-standing fascination with breath-based diagnostics.

## "No One Else was Interested" - and That's How it Started

To understand why van Meerbeeck's voice carries so much weight in lung cancer, you have to start with a detail he offered almost casually: he didn't choose lung cancer because it was fashionable, well-funded, or full of ready solutions. He chose it because, as a trainee in respiratory medicine, *there was effectively a vacuum*.

Lung cancer cases were rising, he recalled, but "*there was no one specifically interested*" in owning the clinical complexity, especially systemic therapies, which at the time were limited and often blunt. What captured him early was small-cell lung cancer: dramatic responses that revealed chemotherapy could matter, even if durability was rare.

From there, his career became a tour through Europe's thoracic oncology ecosystem. He began in Antwerp, where he trained, graduated, and later earned his PhD; moved to Erasmus MC in Rotterdam during a period of institutional growth; returned to Belgium to help lead programmes at Ghent University Hospital; and eventually came back to Antwerp to head thoracic oncology and respiratory medicine near the end of his formal hospital career. Even after retiring from full-time hospital work, he stayed active, still supervising fellows and continuing research with his team.

That mobility wasn't incidental. Later in our conversation, he framed it as deliberate advice: *don't build a career by standing still*. If you don't periodically change your environment or focus, your thinking can calcify.

## Four Decades of Change: From "Imagine Staging Without CT" to Immunotherapy

At one point, van Meerbeeck asked me a question back, half rhetorical, half a reminder of how fast medicine forgets its own history:

***"Can you imagine staging a patient without a CT scan?"***

It's the kind of sentence that instantly shrinks your timeline. In his lived experience, the "before" era isn't abstract: it's a memory.

He walked me through the major turning points as he saw them:

Imaging transformation: CT changed staging; PET-CT refined it further.

- Systemic therapy maturation: from a handful of drugs to evidence-based platinum chemotherapy in lung cancer.
- Targeted therapy dawn: early 2000s trials with gefitinib and erlotinib, shifting the field toward molecular selection.
- Immunotherapy's impact: a "groundbreaking effect," reshaping what survival can look like for many patients.
- Technique revolutions in radiotherapy and surgery: the move from large incisions and pneumonectomy as a common "standard," toward minimally invasive and even robotic approaches.

He didn't present this as a victory lap. It sounded more like gratitude for having had a front-row seat, and responsibility to keep pushing, because "for the moment" is never the final chapter.

*Group picture at the occasion of the start of the pilot lung cancer implementation study in 2024.*

## Epidemiology: Lung Cancer Still Follows Cigarettes, Just Not the Same People

Van Meerbeeck's 1997 PhD work examined how lung cancer presents in his region, and he still thinks in population curves and lag times.

His explanation was clear and sobering: lung cancer incidence follows smoking habits with a delay of roughly *20-25 years*. That's why some countries are now seeing a slow decline in male incidence, while female incidence continues to rise in parts of Western Europe, reflecting later uptake of smoking among women. Public awareness is better, and anti-tobacco messaging has helped, he said, but he remains uneasy when he sees young people smoking and taking up other substances as if the lesson hasn't landed.

It's a reminder that "progress" can coexist with worsening statistics, and that prevention, unlike a new drug approval, rarely comes with a dramatic headline.

## Breathomics: The Simplest Biofluid is Also the Hardest to Prove

If there was a topic that lit up van Meerbeeck's curiosity, it was breathomics, the analysis of volatile organic compounds and other signatures in exhaled breath.

He described breath as one of the easiest biofluids to access: we exhale about 15 times per minute, and those exhalations carry compounds that can be sampled and analysed. The attraction is obvious: a non-invasive test, potentially scalable, potentially cheap.

But his path into breath research also had a streak of serendipity. He recalled stories of animals used in detection work, rats deployed in minefield settings, dogs trained to detect explosives at airports, and wondered: if scent signatures can be detected outside medicine, why not in oncology?

**Then came the realism.**

Breath-based diagnostics, he said, are not "close" yet, not because the idea is weak, but because the validation burden is enormous. Biomarkers have steps: discovery, validation, reproducibility, and then the most punishing gate of all, clinical utility. To prove utility, you need randomised comparisons against standard approaches, with thousands of participants, time, and money. His estimate: breath diagnostics will get there, but likely not for at least several years for early lung cancer detection.

The broader literature echoes that balance of promise and challenge: breath analysis has shown potential across multiple approaches, but translation into routine care hinges on robust validation, standardisation, and demonstrating real-world clinical value.

## Mesothelioma: Rare, Relentless, and Still Personal

When our conversation turned to malignant pleural mesothelioma, van Meerbeeck's tone shifted. Not heavier, exactly more intimate.

He traced his interest back to residency years in Antwerp, when the hospital diagnosed its first case and then began seeing numbers rise week after week. He has been studying mesothelioma for roughly four decades since.

*What gives him optimism today?*

He pointed first to chemotherapy advances that emerged at the end of the 1990s, and then to immunotherapy as the major step of the last decade. But he was careful: mesothelioma hasn't enjoyed the same scale of breakthrough seen in melanoma or subsets of lung cancer. Progress exists, but it's slower, and rarity makes large trials hard. Biology matters too: he noted the limited role of classic oncogene-driven targeted therapy and the prominence of tumour suppressor alterations, which makes "targeted agents" less straightforward here.

He also highlighted familial **BAP1 tumour predisposition syndrome** as an area where early detection could matter, and where research is ongoing.

Back to breathomics again: his group has explored breath signatures that might distinguish asbestos exposure from mesothelioma, "promising signals," he said, but once more: validation and clinical utility are the real hurdles.

Proof-of-principle studies in this area have suggested that breath VOC profiles can discriminate mesothelioma from asbestos-exposed individuals, reinforcing why the concept keeps pulling researchers back.

And then he landed on the simplest preventive advice, delivered without dramatics:

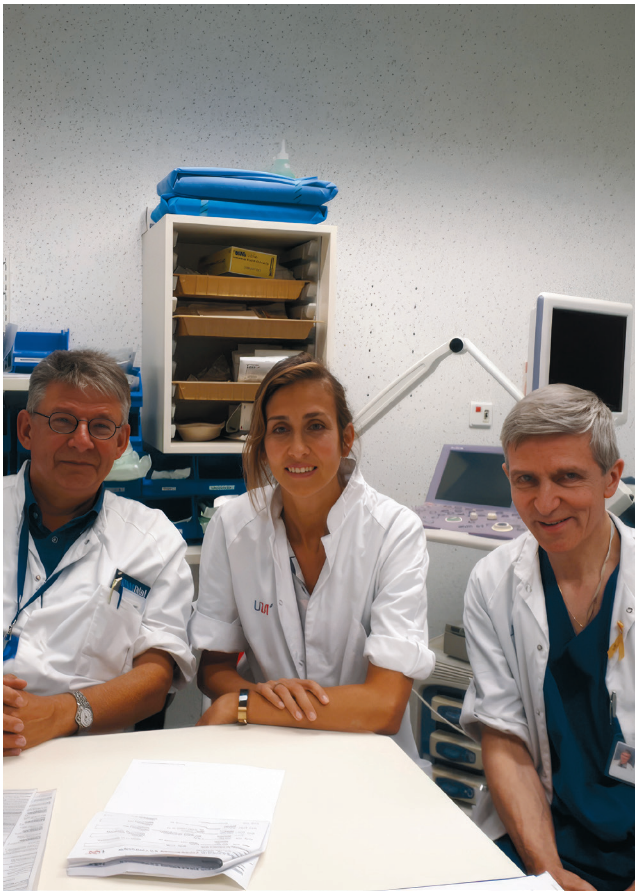
**Avoid asbestos when you're young.**

## Collaboration: Three Words, No Gimmicks

I asked him what makes collaboration work across pulmonology, oncology, and molecular science. He didn't give me a long framework. He gave me three words:

**Communication. Equal partnership. Trust.**

When I pressed him on what he learned steering large international networks, he returned to a familiar European reality: multidisciplinary teams with different incentives and different languages, sometimes literally. In EORTC-linked environments, he said, the challenge is to define a common goal in which every specialty can contribute and receive credit. The strength of those groups has been in multimodality trials, and he regrets how much the field has tilted toward drug-only studies rather than designing integrated approaches.



*At the multidisciplinary outpatient clinic with thoracic surgeon and radiation oncologist.*

With the European Respiratory Society, he argued that pulmonologists' comparative advantage is not "beating" medical oncologists at drugs, but excelling in screening, early detection, diagnosis, and staging, and meeting oncology as an equal partner there.

(Outside the interview, his European roles have also been described in ERS communications and professional bios.)

## Lung Cancer Screening in Europe: Evidence is Not the Same as Implementation

This was the section of the interview where van Meerbeeck became most pointed.

From his perspective, what is still missing to make lung cancer screening equitable across Europe?

First: *political and institutional awareness*. Prevention, he said, isn't popular, because the payoff takes decades and doesn't reliably win votes.

Second: *common European SOPs and GCP-aligned guidelines* for how screening should be done. Europe's diversity is its reality, but it also creates fragmentation, down to basic questions like age thresholds and smoking exposure criteria.

He challenged one assumption directly: relying only on categorical smoking criteria can miss a large fraction of incident lung cancers. Screening cannot be "millions of adults with CT" without smarter risk identification, he argued, especially when each scan carries costs and small radiation risks. This uncertainty becomes convenient cover for inaction, even though cost-effectiveness evidence exists.

**So, what should health systems do now?**

His answer was practical: start with **local implementation studies** that focus on operational endpoints rather than mortality right away. How will you reach people, through GPs, health systems, medical files, invitations? How do you avoid missing those he described as the "fourth world", people with lower health literacy who may smoke more and access care less? Above all: avoid "cherry-picking," where only well-informed, wealthy participants are screened. Screening must be truly population-based to be equitable.

**Overdiagnosis: "a false issue" (and a timing problem)**

When I asked about overdiagnosis, he surprised me: he called it a "false issue", not because it never exists, but because it is often misused as an argument against screening.

Overdiagnosis rates fall the longer you follow people after the last screening round. Analyse too early and you inflate the problem. He noted recommendations that you should wait at least as long as the screening interval span before judging overdiagnosis properly. Practically, he also emphasised restricting screening by age and comorbidity to maintain net benefit.

And then he made an uncomfortable point: in an individual patient, you can't truly know whether a diagnosed cancer was "overdiagnosed," because most will be treated, so the counterfactual is unknowable.

## Innovation, Evidence, and Reimbursement: Put Patients in Trials

As someone with health technology assessment experience, van Meerbeeck has spent years working in the space between scientific promise and reimbursement reality. His approach is almost old-school in its clarity:

If you believe a technique or drug is worth exploring, get patients into clinical trials, your own protocol, or international/national efforts, so they can access innovation while the evidence matures and authorities decide on approval and funding.

It's pragmatic, but it's also ethical: a way to ensure innovation isn't only for the lucky few with access, influence, or cash.

## Advice to Early-Career Clinicians: Become Excellent, then Focus

As a first-year oncology resident I asked what advice he would give someone trying to combine patient care with impactful research.

He answered with the kind of structured simplicity that sounds obvious until you try to live it:

1. First, become a good doctor. Build real experience "on the ground."
2. Choose your topic… your topic. Not your mentor's favourite project.
3. Focus, focus, focus. One, maybe two aspects, don't try to be everything.
4. Don't despair. Find like-minded colleagues, including international networks.
5. Let every patient connect to science. Build a portfolio of trials so each patient encounter has a pathway into learning and evidence.

It wasn't motivational fluff. It felt like a survival plan for an academic life that could otherwise dissolve into scattered effort.

## What He's Proud of and Why He's Still "In the Trenches"

Looking back, van Meerbeeck named three sources of pride.

First, the most human one: training around 25 thoracic oncologists in Belgium and the Netherlands. If each carries forward a piece of "principles of thoracic oncology," he said, that multiplies impact beyond any single paper.

Second, his own career mobility: moving countries, changing focus, refusing to stay fixed. He urged clinicians to dare to change what they do every decade at most, to broaden, rather than narrow into habit.

Third, breathomics: the research track he believes will endure, precisely because it was "completely innovative" when he began, and because others are now carrying it forward, postdocs, tenure-track colleagues, a growing field.

***And motivation?***

"As long as there will be lung cancer," he said, "we have to fight it. And I'm ready to be in the trenches for that."

It didn't sound like a slogan. It sounded like a steady decision he keeps renewing.

## Blitz Round: Jan van Meerbeeck in Short Answers

To close, I asked him a set of rapid-fire questions, small windows into how he thinks when he isn't giving a lecture.

***What's the first thing you do when you get to the hospital or lab?***
Check the agenda with the secretary and anticipate problems before they happen.

***Name a book, paper, or thinker who influenced your scientific outlook.***
Two key mentors (from Amsterdam) who shaped his training and research trajectory; a memorable EORTC-stage experience from a randomised trial in stage III NSCLC; and a book on Artificial Intelligence in Medicine that opened his thinking even before the ChatGPT era.

***If you weren't a doctor or researcher, what would you be doing?***
Astronaut as a dream; more realistically, a **civil pilot**. And this was one of those unexpectedly warm little moments that briefly turned the interview into a shared human exchange: his "other life" mirrored mine. I admitted that if medicine hadn't claimed me, the cockpit would have been my alternative horizon too. For a few seconds we weren't talking about trials, staging, or screening programmes, we were two people smiling at the same old daydream, recognising in each other that mix of discipline, curiosity, and love for wide open space. It was a small similarity, but it left me with a quiet sense of closeness and genuine fondness that lingered long after the call ended.

***What might your students or colleagues be surprised to learn about you?***
His day has 24 hours, just like theirs.

***One word (or sentence) that describes your approach to science and life.***
"Research is what I'm doing when I don't know what I'm doing."

***What keeps you hopeful about the future of cancer research?***
The challenges, and the way new insights become new treatments, from gene-editing possibilities (he mentioned CRISPR) to future targeted approaches.

***Whom should we interview next, and why?***
A colleague he admires: Harry Groen (Groningen), for his broad interest across thoracic oncology from screening to advanced disease.

When the call ended, I wrote down the three words he gave me about collaboration, **communication, equal partnership, trust**, because they didn't sound like advice for "working better." They sounded like a stance toward people.

In the end, that may be the most striking thing about Jan van Meerbeeck: he has spent forty years watching technologies rise and fall, yet he still speaks as if progress depends less on a single miracle tool and more on whether we can build systems and relationships that deserve the science we already have.

And if breath can one day help us detect thoracic cancers earlier, perhaps it will be because people like him kept doing what he described, with characteristic understatement: staying in the trenches, and refusing to mistake complexity for an excuse to stop.

# 2026 Will Be the Year We Analyze Our Own Emotions

By Adrian Pogacian

At 3:00 a.m., in a quiet oncology ward, empathy is no longer an abstract virtue.

It is a muscle pushed beyond endurance.

Oncology healthcare providers build patients' hope and offer as much empathy as possible. Empathy, the ability to experience and understand the feelings of others from their perspective, plays a crucial role throughout the cancer care trajectory. Consequently, patients expect empathy from their medical team and consistently prefer healthcare professionals who are able to offer it.

Yet empathy is a costly resource. It requires a high level of emotional energy and constant psychological availability.

This process rests on several assumptions that are rarely questioned:

- Both the healthcare professional and the patient have emotions
- Both express those emotions

- Both remain attentive to one another's emotional states

Repeated daily, these assumptions carry a price.

## How Much Do Emotions Cost Us?

By definition, we cannot control the length or the intensity of our emotions, and emotions are among the greatest consumers of human energy. During long night shifts, when hard work never sleeps, oncology healthcare professionals experience emotional distress on a daily basis. As a result, they may feel sadness, anger, distrust, guilt, and grief.

Over time, some develop increased fatigue, depression, insomnia, and the phenomenon often described as "feeling the pain" of others. Excessive thoughts about patients, chronic negativity, low morale, diminished empathy, feelings of helplessness, and poor concentration frequently follow. The list goes on.

This is only one part of their journey. The other part unfolds at home, within their personal and family lives. Do they still find the necessary energy to smile, to remain calm, to understand those who are waiting for them there?
Emotions cannot be divided, because a human being cannot be broken in two.

## The Noble Justification, and its Limits

By routine, we tend to believe that our psychosocial distress serves a noble purpose. We accept it as the price of meaning. But in a world increasingly marked by imbalance, insecurity, conflict, and constant pressure to deliver outcomes in minimal time with fewer resources, we must ask: **is this price not becoming too high?**

When, or where, should emotionally driven actions be diminished?

As a professional myself, the answer is not today. And perhaps that is precisely the problem. We often end up fooling ourselves, simply to keep moving forward, pushing the limits of what we believe gives life its meaning.

## Flexibility as a Requirement for Inner Peace

The desire to help is no longer sufficient in our vast and complex world, one now shaped by digital interventions and artificial intelligence. Flexibility becomes a critical construct in emotional expression, particularly as many healthcare professionals repress their emotions to avoid appearing vulnerable in the face of daily challenges.

To provide optimal care, healthcare professionals must be empathetic and compassionate, this is a fact. Yet they must also be creative, flexible, and adaptive in order to maintain balance between professional duty, emotional involvement, and private life.

Stopping empathy is not the solution.
Neither is sacrifice without limits.

## What Technology Cannot Carry for Us

Artificial intelligence will never feel empathy or compassion in the way another human can. What it offers are simulations of emotion, not lived experience. Given the chronic uncertainty of cancer and the variability of individual human responses, person-centered care and human connection must remain priorities.

Authentic empathy, psychosocial understanding, and emotional support can only be provided by people.

Paradoxically, this new wave of technological advancement will not simplify patient–clinician interactions. It will make them more complex, whether they occur in person or through digital means.

## Why This Moment Matters

If emotional demands continue to rise while emotional awareness remains unexamined, the system will fail not through lack of innovation, but through silent depletion.

In 2026, analyzing our own emotions can no longer remain implicit, postponed, or ignored. Without flexibility and self-awareness, empathy itself becomes unsustainable.

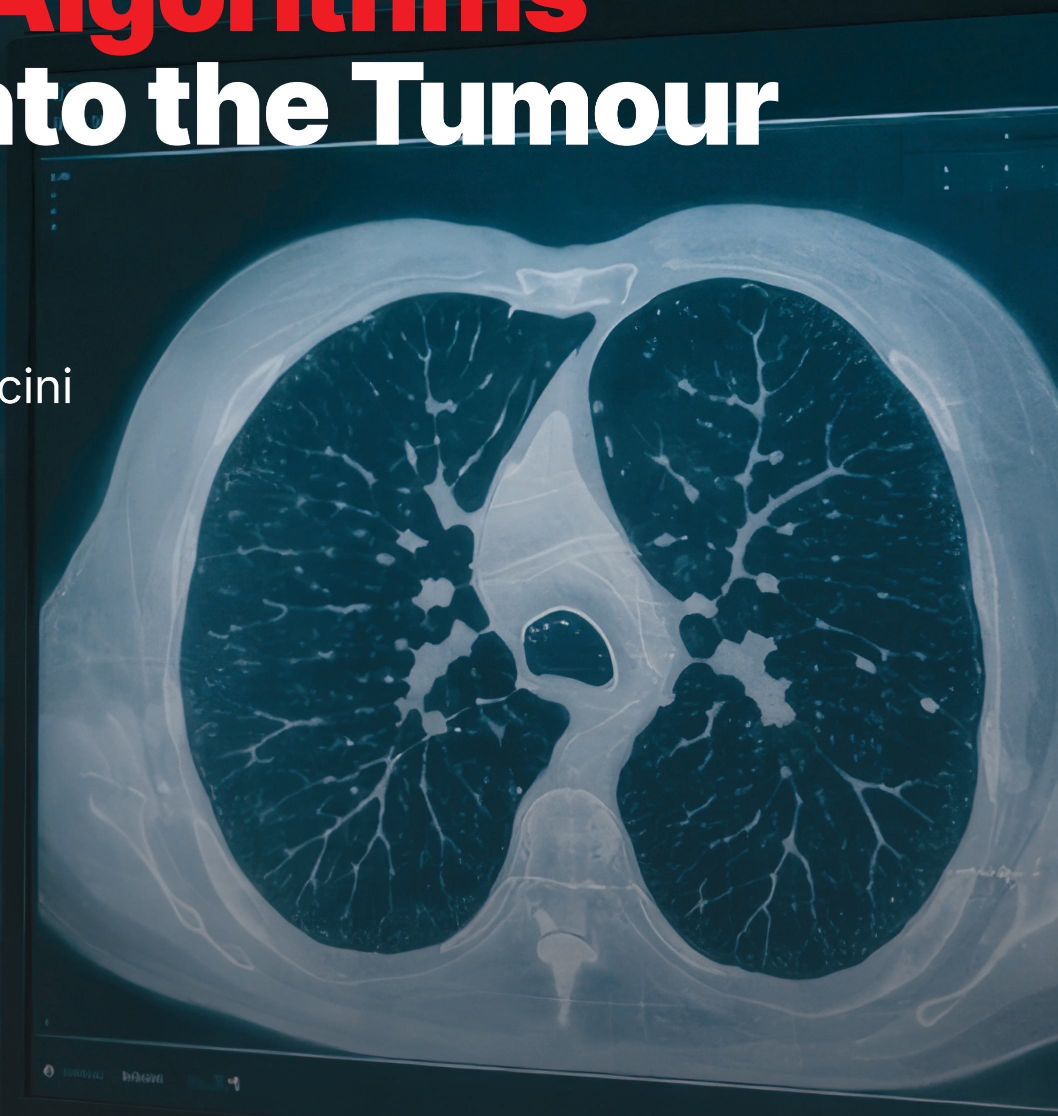
And if we fail to recognize this, we will not lose our humanity all at once, but gradually, quietly, one exhausted caregiver at a time.

## About the Author

**Adrian Pogacian PhD**, is a licensed clinical psychologist with advanced training in psycho-oncology. His expertise is on Coping with Cancer, Complicated Grief, Posttraumatic Growth and Meaning-Centered therapy approach.

# When Algorithms Walk into the Tumour Board

By Luca Bertolaccini



Thoracic oncology is undergoing a quiet transformation that is unfolding in data centres, imaging workstations, and multidisciplinary meetings, where streams of numbers are beginning to stand beside CT scans and pathology slides. In lung cancer, still the leading cause of cancer-related death worldwide, this shift carries enormous weight. Every clinical decision, from early detection to the choice of surgery, radiotherapy, or systemic treatment is currently impacted by the availability of artificial intelligence (AI).

This is not a story about machines replacing clinicians. It is a story about expanding what clinicians can see, quantify, and anticipate. AI does not change the ethical heart of medicine, but it does change the scale at which medicine can operate. The critical question is no longer whether AI will influence thoracic oncology, but whether it will be used rigorously, responsibly, and in ways that truly benefit patients.

## Seeing More in Every Scan

Modern lung cancer care begins with imaging. Yet despite extraordinary technological advances in CT and PET scanning, interpretation remains a human process.. Over the last decade, AI has begun to change this landscape by learning how to recognise subtle patterns that escape the human eye.

Radiomics, a technique that transforms medical images into large sets of quantitative data has transformed what once appeared as a static image into a biological dataset.

Instead of seeing a tumour simply as a shadow on a scan, radiomics breaks it down into hundreds of numerical features that describe its shape, texture, and internal complexity. These features can then be linked to tumour aggressiveness, response to therapy, and predict the risk of recurrence.

The results are striking. AI systems have demonstrated impressive accuracy in detecting small lung nodules, distinguishing benign from malignant lesions, and assisting in staging. For radiologists, this means that AI can work as a silent second reader, reducing the number of lesions that would otherwise be missed and improving consistency. For patients, it means a greater chance of catching the disease earlier, when treatment is most effective.

## Beyond Diagnosis: Anticipating Risk and Outcome

Thoracic surgeons and oncologists constantly face difficult questions: Which patient will tolerate surgery? Who is at higher risk of complications? What is the real likelihood of relapse?
These are not abstract concerns; they determine whether a patient is offered a lobectomy, a sublobar resection, stereotactic radiotherapy, or systemic therapy.

Machine-learning models are now being developed to address these uncertainties by combining clinical characteristics, lung function tests, imaging data, and pathological information to provide an estimate of postoperative risk and long-term outcomes.. In the setting of multidisciplinary tumour boards, some centres are experimenting with AI-based systems that provide real-time estimates of surgical complications and survival. These systems add a layer of quantitative foresight to clinical discussion.

In parallel, natural language processing tools can extract key clinical events from thousands of electronic reports in seconds, reducing the burden of manual data review and enabling real-time surveillance of toxicity, complications, and disease progression across entire patient populations. In an era where cancer care generates immense volumes of unstructured data, this form of automation may prove transformative.

## Why Methodology Matters More than Ever

Behind every successful AI system lies a less visible but decisive element: methodology. Early attempts to apply artificial neural networks in lung cancer showed promise. Still, they also revealed how fragile these systems can be when built on small datasets, weak validation, or poorly designed studies. An algorithm that performs brilliantly on the data used to create it may fail when exposed to new patients in the real world.

For this reason, modern AI research in medicine is increasingly governed by strict reporting and validation standards. Frameworks such as TRIPOD and its recent AI-focused extensions require researchers to show precisely how models are built, tested, and validated. This transparency is not a bureaucratic burden; it is the only way clinicians can learn to trust predictions that may one day influence life-changing decisions.

In lung cancer research, the dangers of overfitting are particularly acute. Postoperative mortality and recurrence are relatively infrequent events, and when models are built with too many variables on too few patients, they risk producing elegant but unreliable predictions. The lesson is clear: in clinical AI, bigger and cleaner datasets matter as much as more intelligent algorithms.

## Not All AI is the Same

Public enthusiasm for AI has exploded with the rise of large language models capable of producing fluent text. Yet in medicine, it is essential to distinguish these tools from genuine clinical AI systems. A language model can summarise an article or generate a report, but it cannot analyse patient-level data, perform validated statistical inference, or provide calibrated numerical risk estimates. It may produce output that sounds authoritative while being factually incorrect.

Clinical AI models operate in a very different domain. They are trained on structured medical data, tested against independent patient cohorts, and evaluated for accuracy, calibration, and reproducibility. Confusing these two worlds risks undermining trust in medical AI as a whole. For clinicians, patients, and policymakers, clarity on this distinction is not an academic detail; it is a matter of safety.

## The Ethical Fault Lines in Academia

As AI tools become more accessible, a new set of ethical challenges is emerging in academic medicine. Cases have already surfaced in which fabricated analyses, figures, and even entire manuscripts have been generated using language models. Such content can appear convincing on the surface while being entirely disconnected from real data.

The danger is not only reputational. If fabricated material enters the scientific literature, it can contaminate systematic reviews, meta-analyses, and eventually clinical guidelines. The consequences would not remain on paper; they would reach the bedside. Editorial organisations and publication ethics bodies now stress that generative AI must never replace responsibility for data integrity, authorship, and verification. Transparency, disclosure, and human oversight are essential safeguards.

## The Statistical Backbone of Trustworthy AI

Every reliable AI system in medicine is anchored in classical biostatistics. Issues such as sample size, missing data, event rates, and external validation are as central to machine learning as they are to traditional clinical research. No algorithm, however sophisticated, can escape these constraints.

Another critical challenge is dataset shift. Patients seen in one hospital are never the same as those treated elsewhere. Imaging protocols differ, surgical techniques evolve, and demographics change. An AI tool that performs perfectly in one environment may degrade in another unless it is continuously monitored, updated, and revalidated. This reality reinforces the need for collaboration across centres and countries, as well as long-term performance surveillance.

## From Research Tool to Clinical Instrument

For patients, the most frequent question remains a simple one: Is a machine making decisions about my care? The answer, today and for the foreseeable future, is no. AI tools in thoracic oncology function as clinical support instruments. They inform, but they do not decide. The final responsibility remains firmly in human hands.

Regulation is beginning to reflect this delicate balance. In Europe, the new AI Act classifies many medical AI applications as high-risk systems, subject to strict requirements for transparency, safety, and post-market surveillance. In the United States, regulatory authorities are refining pathways for software as a medical device, with increasing emphasis on real-world performance and continuous oversight. These frameworks are still evolving, but they signal a clear direction: AI will not enter routine care without defined legal and ethical guardrails.

Economic and organisational factors will also shape the future. Even the most accurate algorithm cannot improve care if it remains confined to research platforms. Reimbursement models, health technology assessment, and integration into hospital workflows will determine whether AI becomes a routine companion in thoracic oncology or remains a promising niche technology.

## A Human Discipline, Supported by Machines

Despite all technological progress, lung cancer care remains a profoundly human endeavour. No algorithm can replace compassion, empathy, or the delicate communication required when discussing diagnosis, prognosis, and treatment with patients and families. At its best, AI does not threaten this relationship; it protects it by reducing uncertainty and supporting better-informed decisions.

One can already imagine the tumour board of the near future. Alongside imaging and pathology, a small screen quietly displays predicted risks and expected outcomes. Not a verdict, but an additional voice. One that clinicians may accept, challenge, or ignore, guided by experience, evidence, and the individual patient sitting in front of them.

## Conclusion

AI is reshaping thoracic oncology not through dramatic disruption but through incremental refinement of decision-making. It offers earlier diagnosis, more precise risk stratification, and the possibility of personalised treatment pathways. Its power, however, depends entirely on how it is built and governed. Without methodological rigour, transparency, and ethical discipline, AI risks becoming a source of illusion rather than insight.

If used wisely, AI will not replace surgeons or oncologists. It will strengthen their judgement, sharpen their precision, and extend what is clinically possible. The mission of lung cancer care remains unchanged: to cure more patients, alleviate suffering, and deliver the appropriate treatment to the right person at the right time. AI, responsibly developed, can help bring that goal closer.

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