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**Christa
Mather**

One foot in
front of
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WELCOME

by Laurelle Williams

The theme of this issue is **Red = Determination**. I like vibrant, strong reds; I pay money for my hair to be coloured this shade of red, and as Christian Dior said, "Bright reds – scarlet, pillar-box red, crimson or cherry – are very cheerful and youthful. There is certainly a red for everyone."

In *When resources fall short* and *Moral distress among healthcare professionals*, it can only be pure determination and passion that helps healthcare practitioners overcome these serious obstacles. Thank you to both doctors for giving us a glimpse into their realities.

One foot in front of the other showcases the wonders of new drugs and how they are improving cancer outcomes. We wish you a happy retirement, Christa Mather.

World Hospice and Palliative Care Day takes place on 10 October and Dr Margie Venter explains why this day is essential in *Because your days matter* while Dr Nelia Drenth explores *The silence around dying*.

Until the next issue, carry the spirit of red with you.

Red protects itself. No colour is as territorial. It stakes a claim, is on the alert against the spectrum."
– Derek Jarman

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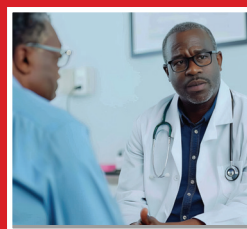
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Mission

Oncology Buddies informs and inspires all those who have, or are affected by cancer. Oncology Buddies is committed to working with all stakeholders to find solutions aimed at improving the quality, lifestyle, satisfaction, enjoyment and activities of people affected by cancers.

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WHEN RESOURCES FALL SHORT

Dr Memory Bvochora-Nsingo reveals the reality of moral distress in African healthcare, where a lack of resources can leave healthcare professionals facing difficult choices.

I arrived in Malawi this year on 6 July, Malawi's Independence Day. Across the country, Malawians were commemorating the day, in 1964, when their nation gained independence from British colonial rule. There was something deeply symbolic about arriving on such a day. While Malawi celebrated more than six decades of national independence, I had arrived as an expert under the International Atomic Energy Agency (IAEA) programme to support and mentor a team taking another important step towards self-reliance: building the capacity to offer women with cervical cancer complete, potentially curative radiation treatment within their own country.

As in many countries across sub-Saharan Africa, cervical cancer remains the most common cancer among women in Malawi and a leading cause of cancer death, making access to effective curative treatment particularly urgent.

Malawi had recently commissioned and started high-dose rate (HDR) brachytherapy, an essential component of curative treatment for cervical cancer. Brachytherapy delivers a concentrated dose of radiation directly to the tumour and without it, treatment is incomplete. The excitement among the local team was tangible; after years of having no access, they could finally offer women a complete pathway towards cure.

But almost immediately, we encountered a painful dilemma.

TOO MANY WOMEN TO TREAT

A long-standing backlog had developed. Some women had completed external beam radiotherapy months earlier and had been watching the arrival of brachytherapy with hope and expectation. They had waited patiently for their opportunity.

But there was now another group: women currently undergoing radiotherapy. For cervical cancer, time matters. External beam radiotherapy and brachytherapy should ideally be completed within 50–56 days. Delaying these women to clear the historical backlog could compromise their chances of cure.

WHO SHOULD BE TREATED FIRST?

I sat with one of the local doctors, Christine, as she studied the waiting list. I could see two emotions simultaneously: the enormous joy of finally having brachytherapy and the anguish of knowing that the service couldn't immediately accommodate everyone who needed it.

We examined dates and calculated treatment intervals. We discussed whether treatment remained curative or had become palliative. We asked how we could honour women who had already waited so long without creating another generation of women whose treatment would also be delayed.

There was no perfect answer. This, for me, is the reality of moral distress in African healthcare: knowing what your patients need but not having enough resources to provide it for everyone. In a well-resourced setting, we ask, *What is best for this patient?* In a resource-limited setting, we are forced to ask, *If I treat this patient, what happens to the next one?*

Behind every name on that waiting list was a woman hoping for more time. I remember telling Christine, "You have started. You are moving forward." We can't always change what we lack today, but we can use what we have wisely and compassionately while continuing to build for tomorrow.

SO, WE WORKED

We reviewed patients, refined processes, taught, learnt from one another, and treated women. During that mission, the team successfully delivered CT-guided brachytherapy to 13 women in three days. The joy among the clinicians was extraordinary. These were professionals who had always possessed the knowledge, commitment, and compassion to care for their patients. They now had the tools to translate that commitment into potentially curative treatment.

My experience in Malawi reminded me of visits to other parts of Southern Africa where access to radiotherapy is absent. It

also reminded me of Botswana, where I have witnessed what sustained access to radiotherapy and brachytherapy can achieve. I have seen women with cervical cancer return years after treatment, cancer-free, working, raising children, and living their lives.

As Malawi celebrated its independence that week, we too celebrated, not because every problem had been solved, but because something important had begun.

YESTERDAY WE COULD NOT, TODAY WE CAN

There was still a backlog, difficult decisions to make, and much work ahead. But perhaps compassion doesn't require us to solve every problem before we allow ourselves to celebrate progress. It asks us to recognise suffering, to use wisely what is in our hands, and to keep moving forward.

Moral distress reminds us of what is still missing. Compassion moves us to act. And progress gives us reason to hope.

As Malawi celebrated its independence, I celebrated with the remarkable team at the National Cancer Centre, a team building its own capacity to offer women with cervical cancer a chance of cure at home.

Happy Independence, Malawi. And to the National Cancer Centre, Zikomo—thank you for allowing me to be part of your journey.



MEET THE EXPERT

Dr Memory Bvochora-Nsingo is a clinical oncologist with 20 years of experience in radiation oncology and chemotherapy, specialising in the treatment of cancers

of the cervix, breast, prostate, head and neck, and many others. She has worked for 16 years in Botswana, achieving significant success in both curative and palliative care, including end-of-life care. Currently, she works at Gaborone Private Hospital and is involved in government work as well.

Moral distress among healthcare professionals

Dr Linda Rogers shines a light on moral distress among healthcare workers in South Africa.



I'm a surgeon sitting in my office when I should be operating. I will not be operating again tomorrow, despite the waiting list for female cancer operations extending into February 2027.

Thanks to the austerity measures inflicted on the public health sector by national government, hundreds of patients are having to suffer and wait an unacceptably long time for their life-preserving surgery every year.

Managers are employed, but posts for doctors and nurses are frozen as soon as someone moves jobs or retires, leaving us extremely short-staffed. To add insult to injury, two weeks ago the last of our three boilers (used to sterilise instruments) broke down, meaning another day of theatre-time was lost. Nobody has explained what led to the other two boilers not functioning for long periods of time.

We have lots of administrative, teaching, and research work to do, but the real need is for surgeons to be in theatre, operating on sick, injured, or bleeding patients. We swore an oath to *First, do no harm*, yet we are unable to do our best for our patients, due to the financial constraints in which we work. This is causing an epidemic of moral distress among healthcare workers.

MORAL DISTRESS AMONG SOUTH AFRICAN HEALTHCARE WORKERS

Moral distress occurs when healthcare professionals can't carry out what they believe to be appropriate management of their patients, due to constraints placed upon them by others or by the healthcare system in which they work. It's increasingly being recognised to be the most important

occupational health hazard for healthcare workers in South Africa.

As a result of the high levels of poverty, unemployment, and violence in South Africa, providing healthcare to our patients can be more difficult and distressing than elsewhere in the world.

The severe healthcare budget cuts, as well as corruption and mismanagement in the public healthcare sector have added to and compounded this distress, leading to a situation where "the burden of care that healthcare workers in South Africa shoulder as a result of failings in service delivery in the public healthcare sector is having devastating effects on the healthcare workers themselves."¹

In our two-tiered healthcare system, this burden also occurs with increasing frequency in the private sector, when medical aids or insurances refuse authorisation for investigations, drugs, and procedures, often based on cost, rather than on what is best for the patient.

In the last few weeks, I have had authorisation for a patient with a gynaecological problem declined with no reason given, even though her general practitioner referred her and applied for authorisation. She had a justifiable reason to be referred to a specialist and hadn't yet made use of any of her allocated specialist visits for the year.

I also had to write a letter of motivation for a patient with endometrial cancer to have a laparoscopic hysterectomy; this procedure is the gold standard management for this condition, so it's not clear why a letter of motivation was required.

UNDERSTANDING THE CONCEPT OF MORAL DISTRESS

The concept of moral distress originated in the field of nursing. It can be caused by several broad categories of constraints, including:

- Being unsure what the correct course of action is and having inadequate support and supervision to assist in the decision-making process.
- Knowing the correct course of action or treatment but being unable to follow it due to being compelled to perform an alternative by someone else, or by system/financial constraints, or by fear of litigation.
- Bullying and/or abuse in the workplace.
- Power hierarchies which compromise patient care.

It can occur in a diverse range of contexts and can lead to the related concept of moral injury, a form of post-traumatic stress disorder (PTSD) which has been described as "unique to those who bear witness to intense human suffering"², as well as to burnout.

HEALING HEALTHCARE WORKERS AND THE HEALTHCARE SYSTEM

Important first steps are recognition of the scale of the problem and rejection of the stigma attached to poor mental well-being in healthcare workers. Pressure on political leaders, to demand a halt to austerity measures and reinvestment in public healthcare is vital.

In the workplace, group discussions and clinical ethics forums can assist healthcare workers in difficult decision-making and provide support for each other's distress.

Patients and healthcare workers need to be aware of their rights and should be encouraged to question unfair and illegal medical aid practices, and to vote against corruption and maladministration. 

To view references, visit oncologybuddies.com



MEET THE EXPERT

Dr Linda Rogers, a gynaecological oncologist, has worked as a senior specialist in the Department of Obstetrics and Gynaecology at the University of Cape Town (UCT) and Groote Schuur Hospital (GSH) since 2009. She is assistant editor of the *South African Journal of Gynaecological Oncology* (SAJGO) and is a member of the South African HPV Board.

Because your days matter

**Dr Margie Venter
highlights why World
Hospice and Palliative
Care Day is so important
because your days matter.**



Nearly every day on the calendar is dedicated to something. Cancer awareness days, in particular, have played an important role in shaping awareness, education, and funding.

World Hospice and Palliative Care Day is on 10 October, and palliative care really does need its day.

I've been mulling over what to write for weeks. Palliative care still carries such a negative connotation. For many people, the words suggest giving up hope, dying, or those last few days of life. Most people would rather not know too much about it until they absolutely have to.

Which is precisely why it needs a day: to bring it out of the shadows. Because, really, palliative care is about living and helping people live with as much quality as possible.

I've also been wondering which of my hats I should wear while writing this. The

family member hat, having loved someone with advanced cancer who needed palliative care when I was still a junior doctor? The ex-oncologist-now-palliative-care-doctor hat? Or my palliative care advocacy hat?

The advocacy hat is probably the right one. It sounds rather grand and conjures up images of legal experts in impressive regalia.

OTHER HATS MATTER TOO

As a family member, my message is very simple: Don't delay. Ask for palliative care. You don't know what you don't know. We certainly didn't.

As a palliative care doctor, I would add something else: your oncology team may need you to ask. Oncologists can find it difficult to introduce palliative care because they know what many patients hear when the words are mentioned:

They have given up on me. That is not what is meant.

Cancer treatment requires enormous focus from your oncology team. Palliative care adds another team whose particular focus is you: your pain, symptoms, worries, function, family, difficult decisions, and quality of life while all that cancer treatment is happening.

For me, there are few things more satisfying in medicine than helping somebody get their pain under control. Pain can swallow an entire day. Relieving it can give that day back.

PAIN MANAGEMENT

Appropriately, the theme for World Hospice and Palliative Care Day this year is *Pain Management: An Essential Part of Palliative Care*.

And this is where I put the advocacy hat firmly on.



Practitioners of South Africa (PALPRAC). Patient stories help us advocate for change, because it's much harder to ignore a gap in healthcare when we can show what that gap means to a real person and family.

The same is true in the public sector. If you receive your oncology care through a state hospital, ask whether there is a palliative care service attached to the oncology unit or hospital. Access remains very uneven across South Africa, and in many areas much of this support is still provided by local hospices. If that is what is available, ask for a referral.

BROADER WORK NEEDS TO BE DONE

South Africa's National Palliative Care Policy and Strategy is currently being reviewed, after the previous policy lapsed in 2022. Most importantly, once finalised, it needs to be implemented. Healthcare professionals can advocate for that, but civil society matters enormously too. Patients and families asking, *Why is this care not available here?* can be powerful. Which brings me back to hats.

Children need palliative care too. Every year, the paediatric palliative care community runs the *Hats On 4 Children's Palliative Care* campaign. On Friday, 9 October, people are encouraged to wear a hat to work, school, or wherever they happen to be, to raise awareness of the children and families who need this kind of support.



So, perhaps there is something useful about having a day after all. World Hospice and Palliative Care Day gives us an excuse to talk about something we often avoid talking about. And if you are living with cancer, perhaps this is the most important thing I can leave you with: palliative care is there to help you live as well as possible while you are living with serious illness. You don't need to wait until things are desperate. Ask early. Your day matters. 

I feel strongly enough about palliative care that I spend about half of my professional life trying to make sure it becomes part of ordinary healthcare for people living with serious illness. I have seen what a difference it can make to the journey of a patient and family.

Palliative care isn't a luxury or a nice extra. Access to palliative care is recognised as a human right, the right to the highest attainable standard of physical and mental health. That includes access to pain relief, medicines to manage other distressing symptoms, and healthcare professionals who know how to provide this care.

The World Health Organization puts it rather clearly, "Palliative care is a crucial part of integrated, people-centred health services. Relieving serious health-related suffering, be it physical, psychological, social, or spiritual, is a global ethical responsibility."

So yes, you can ask for it. And you should.

PRIVATE VS PUBLIC

If you belong to a medical scheme, ask what palliative care benefit is available to you. Patients living with serious illness should have access to appropriately trained palliative care professionals and the medicines needed for symptom relief. Ideally, this care shouldn't require additional co-payments, nor should its costs simply eat away at the oncology benefit intended to treat the cancer.

Some South African medical schemes have made important progress in this area. Others still have work to do.

If your scheme doesn't provide adequate palliative care cover, please ask questions. Engage with them. And tell us at the Association of Palliative Care



MEET THE EXPERT

Dr Margie Venter is an oncologist and palliative care doctor based in Stellenbosch, Western Cape. She is the clinical director of PALPRAC, the Association of Palliative Care Practitioners of South Africa, an organisation that provides national leadership and advocacy for the equitable provision of palliative care to all South Africans.

The silence around dying

Dr Nelia Drenth explores how family efforts to protect their loved one can affect how they cope and create silence around dying.

There is a land of the living and a land of the dead, and the bridge is love, the only survival, the only meaning.
~ Thornton Wilder

There is a particular kind of silence that often enters a family when someone is facing a life-limiting illness. It's not the quiet of peace or acceptance. It's a careful, watchful silence, filled with half-truths, changed subjects, forced optimism, and unspoken fears.

This silence is usually born out of love. Families want to protect the person who is ill from pain, despair, or giving up. And quite often the patient is silent for the same reasons as the family. Yet, unintentionally, this protection can make the journey lonelier and heavier for both the patient and the family where everybody tries to shield each other.

WHY FAMILIES GO QUIET

Families often believe that talking openly about dying will take away hope, increase fear of upsetting the patient, and cause them to lose motivation to live while dying. There is constant conflict between holding on and letting go. Grief becomes a silent partner from the moment of the diagnosis of a life-threatening illness and continuous after death.

In many cultures, including here in South Africa, death is a difficult topic, sometimes taboo, sometimes surrounded by strong beliefs about positivity, faith, or resilience. Silence becomes a way of coping. If you don't name it, perhaps it won't happen. Moreover, this state makes it difficult to deal with imminent death as it obstructs saying farewell in time, heal broken relationships, and making necessary arrangements.

But illness has a way of speaking its own truth. The body knows. The person who is ill often knows more than families realise.

WHAT THE PERSON WHO IS ILL MAY EXPERIENCE

When conversations about dying are avoided, patients frequently describe a deep sense of isolation. They may think that they must protect their family from their emotions. This can make them feel isolated in their own illness.

This silence can interrupt an important psychological process. Many people facing serious illness move back and forth between hope and fear, living and preparing, fighting and adapting. When dying is not acknowledged, patients may be denied the space to ask questions about what lies ahead, express fear, sadness, anger, or peace, say important things to the people they love, engage in legacy work or life review, and make choices about their care, relationships, or unfinished business.

Coping is about being allowed to be real.

PROTECTION CAN BECOME A BURDEN

Ironically, silence often shifts the emotional burden onto the patient. Instead of being protected, they become the protector – monitoring their words, hiding tears, reassuring others, and carrying their fears alone.

This emotional labour is exhausting. We can't deny that dying is hard. While the family and loved ones are saying goodbye to one person, the person with a life-threatening illness, is saying goodbye to everyone and everything.

It's a strength to open conversations during the last weeks. Protection through silence isn't a strength, only a way of coping. Open conversation can be about good memories, achievements, regrets, money, death, the funeral, and forgiveness.

Dr Ira Byock, an advocate for palliative care, refers to the four most important things in life: *Please forgive me. I forgive you. I love you. Goodbye.*

WHAT OPEN CONVERSATIONS OFFER

Talking about dying doesn't remove hope. Instead, it often changes its shape. Hope may shift from cure to comfort, from length of life to quality of life, from fear to meaning, from control to connection.

When families allow space for honest conversations, patients often experience relief from emotional isolation and a sense of greater trust and closeness. But more

important, the freedom to live more fully in the time that remains.

These conversations don't need to happen all at once. They can be gentle, paced, and guided by the person who is ill.

FOR FAMILIES: A GENTLE REFRAME

Protecting someone doesn't always mean shielding them from the truth. Sometimes it means walking with them into it.

You don't need perfect words or answers. You only need presence. Silence can feel safer, but connection is what truly comforts.

FOR THOSE WHO ARE ILL

If you're the one facing illness and feel surrounded by silence, know this: your thoughts and fears are valid. Wanting to talk about dying doesn't mean you are giving up. It means you're human.

Sometimes it helps to invite the conversation gently:

- There's something on my mind I'd like to talk about.
- I don't need fixing; I just need you to listen.
- I want us to be honest with each other.

BREAKING THE SILENCE, ONE MOMENT AT A TIME

The silence around dying isn't a failure of love, it's often an expression of it. But love can grow when silence softens into shared truth.

Talking about dying doesn't make it happen sooner. It makes the time that remains more authentic, more connected, and less lonely.

And in that shared honesty, many families discover something unexpected: not despair, but deep love, courage, and moments of meaning that would otherwise have remained unspoken. 



MEET THE EXPERT

Dr Nelia Drenth is a palliative care social worker in private practice in Pretoria, Gauteng. She presents workshops on psychosocial palliative care and bereavement counselling and has a passion for social work in healthcare.

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One foot in front of the other

Most people would be devastated to hear they have lung cancer, but once Christa Mather learnt that a targeted therapy offered new hope for people with the type of cancer she has, she simply put one foot in front of the other.

Christa Mather (65) lives in Parktown, Gauteng with her husband, Warren. They have a daughter, Katherine (32).

Around April 2024, Christa developed a cough. "It was non-stop coughing; I couldn't even talk, which isn't a bad thing. It felt like something was stuck in my throat," Christa explains.

"I went to a GP, thinking that because I was overweight, maybe it was acid reflux. I was prescribed medication and the doses kept on increasing but the coughing didn't decrease."

Christa made an appointment with a cardiologist as her father had passed away from a heart attack and there is a history of high cholesterol in her family, and since she had never seen a cardiologist, she thought this would be a good time to do so.

In July, she underwent a heart scan; her heart was in good condition, however, a mass on her lung was detected. The cardiologist referred her to a pulmonologist, who then requested that she come in for a bronchoscopy.

Unfortunately, the scope couldn't reach the mass and since Christa had a month-long overseas trip planned in two days' time, she was told to come back after the holiday.

"The trip was lovely. I was just coughing the whole time," Christa recalls.

TWO BIOPSIES

Once back from holiday, she underwent a transthoracic needle biopsy under local anaesthetic, during which a sample of fluid near the lung was taken through her back. She says it was a weird feeling; she could feel a presence and then a sharp but short pain. Unfortunately, the results were inconclusive, so she underwent another biopsy. This time, she was put under general anaesthetic and a surgical lung biopsy through the chest was performed.

FEMALE DOCTOR REQUESTED

Christa recalls receiving the news while at work as surreal. She explains, "No one in our family has had cancer and I wanted more information before I told my husband and daughter. I told my cousin and we went to my first appointment with the oncologist. I requested a female doctor as I was tired of seeing male doctors, and I'm so thankful for her. She is wonderful."

The oncologist explained that Christa has Stage 4 non-small cell lung cancer with an EGFR mutation. This type of lung cancer is commonly found in people who have never smoked.

"I asked the oncologist: *Is it because I smoked for a very short period in my twenties? Is it because both my parents smoked?* But she reassured me that it wasn't. Thankfully, I stopped my social smoking due to developing acne on my neck."

The oncologist went on to explain that since Christa has an EGFR mutation, there is a targeted therapy for this specific cancer which has shown impressive results. Before this drug, outcomes for patients were poor, with survival sometimes measured in only a few months.

"She told me that this cancer likes to spread to the brain. I was more worried about it being in my brain than my lungs. But thankfully, it hadn't spread to my brain but was found in my lymph nodes," Christa explains.

"When I heard that there was a specific drug to treat the cancer, I was relieved and I could process the diagnosis and tell my family I have lung cancer but there is a promising treatment."

FAMILY RESPONSE

Christa's husband and daughter were shocked by the news but accepted it gracefully and most of all wanted her to get better.

"Knowing that there was this drug gave us hope and the oncologist comforted us greatly," Warren says.

Christa adds, "Knowing this miracle drug has changed the face of non-small cell lung cancer (EGFR mutation), I didn't see the need to google the cancer I have."

TARGETED THERAPY

Christa started the targeted therapy in November 2024 and was instructed to take the oral medication at the same time every day.

"In the beginning, I experienced extreme diarrhoea. Luckily at that stage I was working from home two days a week so that helped. But I had two very unfortunate and bad instances at work and thank God we were only ladies," Christa explains.

Other side effects Christa experiences include very sore nerve endings in her fingers, and her hair texture has changed too; it has become wavy and dry, and her scalp is so tender that she can't use a hair dryer. She adds that these side effects come and go in phases.

Almost two years on the targeted therapy, Christa says she has learnt her triggers, such as spicy food and too much sugar, and

adapted to the other changes like putting oil on her hair.

MEDICAL AID COSTS

Christa's medical aid covers 80% of the cost (over R100 000) and the remaining 20% she is liable for. Fortunately, her oncologist applied to a patient assistance programme on her behalf and the programme covers the shortfall.

TEMPORARY DISABILITY

When Christa was diagnosed, she informed her line manager who was very gracious and said if she needs any rest, she must let her know.

Christa adds, "I think since COVID, wellness has become top of mind. We have wellness webinars every week, let it be on addiction, stress, or other issues."

In March 2026, Christa's employer implemented that all staff must be office-based and for three months Christa was travelling to and from work. However, Christa felt the fatigue and wasn't managing everything.

"I wasn't doing my job properly and when I got home, I didn't want to cook and my household tasks were heaping up, even though I have a helper twice a week. I could sleep for three hours after work and then still sleep a full night, so I need a lot of sleep," she explains.

So, she applied for temporary disability, which commenced in July and she will go on full retirement in November. She worked two days a week until August to help with the handover as she felt it was unfair to leave the new person in the lurch.

QUALITY OF LIFE

Besides the fatigue, Christa says her quality of life is good. She has stopped coughing and adds that within a month of treatment, there

was a marked difference. The cancer in the lymph nodes is no longer detectable and the tumour on her lung has shrunk.

"I had a scan in April this year and it was the first time that the cancer hadn't shrunk. In my opinion, the full month of driving to and from work every day may have had an impact. Rest is essential," she says.

When asked how she has accepted the diagnosis and her new normal, she says, "You have the drug, then God (your faith), and family. Warren has been extremely supportive just by listening and talking about it. I don't often speak about faith, but once you face death, your faith system becomes vital. It helped me immensely; at times I was down and just by reading daily devotions brought peace and calmness."

Christa sees determination as one foot in front of the other which is exactly the approach she is taking.

LOOKING TO THE FUTURE

Now that Christa is retired, she hopes to volunteer at an adoption home close to her house. "My daughter has said she won't be having children, so I want to feed the babies, hold them, and talk to them. I also want to get more involved with my church and their soup kitchen. Other goals include starting a vegetable garden, exercising more, and, of course, spending more time with Warren."



MEET OUR EDITOR

Laurelle Williams is the editor at Word for Word Media. She graduated from AFDA with a Bachelor of Arts Honours Degree in Live Performance. She has a love for storytelling and sharing emotions through the power of words. Write to editor@wordforwordmedia.co.za

Lung cancer causes in people who have never smoked

Dr Ronwyn van Eeden helps us understand why people who never smoked get lung cancer.

Lung cancer is the fifth most common cancer worldwide but remains the leading cause of cancer-related death.

When most people think of lung cancer, they immediately think of smoking. While smoking remains the most important risk factor for lung cancer, there is another group of patients who are often overlooked: people who develop lung cancer despite having never smoked.

As smoking rates have declined in many parts of the world due to awareness of the risks, the understanding of lung cancer has also changed. We now recognise that lung cancer in people who have never smoked isn't simply the same disease occurring without the usual risk factor. In many cases, it has its own biological characteristics, causes and, importantly, treatment options.

NOT ALL LUNG CANCERS ARE THE SAME

Lung cancer is broadly divided into two main groups:

Small cell lung cancer (SCLC) accounts for approximately 15% of cases and is very strongly associated with smoking.

Non-small cell lung cancer (NSCLC) accounts for approximately 85% of cases.

NSCLC is further divided into several subtypes, including adenocarcinoma, squamous cell carcinoma, and large cell carcinoma.

Adenocarcinoma is the most common type of lung cancer in never smokers (LCINS).

For research purposes, a never-smoker is generally defined as someone who has smoked fewer than 100 cigarettes during their lifetime. LCINS is seen more frequently in females and is also proportionally more common in Asian populations.

This is why a patient with lung cancer doesn't necessarily look like the person we traditionally picture: an older male with chronic lung disease and a long history of smoking.

Unfortunately, never-smokers don't form part of screening guidelines, despite the rising incidence of high-risk groups that can be identified.

CHALLENGES IN NEVER-SMOKERS

One of the challenges with lung cancer in people who have never smoked is that the diagnosis may not initially be considered.

Symptoms can include a persistent cough, shortness of breath, chest pain, unexplained weight loss, fatigue, or recurrent chest infections. The important warning sign is often a symptom that persists or doesn't improve despite appropriate treatment.

For example, someone may repeatedly receive antibiotics or treatment for allergies or asthma because they don't fit the traditional picture of a person at risk for lung cancer.

This is particularly relevant in South Africa, where diseases such as tuberculosis (TB) are common and can sometimes produce

symptoms or X-ray findings that resemble lung cancer. This can occasionally delay the correct diagnosis.

The message isn't that every persistent cough is cancer. Rather, if symptoms continue despite appropriate treatment, they should be investigated further, even in someone who has never smoked.

WHY DOES LUNG CANCER OCCUR IN PEOPLE WHO HAVE NEVER SMOKED?

LCINS is estimated to account for approximately 15–25% of lung cancers worldwide, although the proportion varies considerably between populations.

There is usually no single identifiable cause. Instead, several environmental, occupational, genetic, and biological factors may contribute. Some chronic lung disease, such as inflammatory lung diseases and sarcoidosis, may also have an association.

Environmental and occupational risk factors include second-hand tobacco smoke, as well as long-term exposure to air pollution, particularly tiny airborne particles known as fine particulate matter. Diesel exhaust, radon, asbestos, and silica exposure are also risk factors. Long-term exposure to these cause chronic inflammation and damage within the lungs over time and increase the risk of developing lung cancer.

Genetics may play a role as well. Having a first-degree relative with lung cancer is



associated with an increased risk, although inherited genetic causes account for only a proportion of cases.

Previous radiation treatment to the chest can also increase the risk of developing lung cancer later in life.

Importantly, however, many people who develop lung cancer despite never smoking have no obvious environmental or inherited risk factor. They shouldn't feel that there must have been something they did to cause their cancer.

GENETICS OF THE TUMOUR: KEY TO TREATMENT

One of the most important discoveries in modern lung cancer treatment is that cancers arising in people who have never smoked are particularly likely to contain specific genetic changes within the cancer cells, known as driver mutations or driver alterations.

A driver mutation acts rather like a faulty switch that tells the cancer cell to continue growing. If we can identify that switch, we may be able to use a treatment specifically designed to block it.

This has transformed the treatment of lung cancer. Some of the best-known alterations involve genes such as EGFR, ALK, and ROS1. Other important targets include RET, MET, BRAF, HER2, and NTRK, among others.

These alterations are considerably more likely to be found in adenocarcinomas occurring in people who have never smoked

than in smoking-related lung cancers.

Targeted therapy has changed the outlook of these cancers and can improve survival and quality of life in patients who receive these treatments.

Once a driver alteration is identified, treatment can often be matched specifically to it.

Many of these treatments are tablets called tyrosine kinase inhibitors (TKIs). Others are given intravenously and include specialised monoclonal antibodies, bi-specific antibodies, or antibody drug conjugates.

Unlike conventional chemotherapy, which attacks rapidly dividing cells more broadly, targeted therapy is designed to interfere with a specific abnormal pathway that the cancer depends upon for its growth.

For patients whose cancers contain these mutations, targeted treatments can produce very high response rates and may control the cancer for prolonged periods.

Some targeted therapies can also penetrate the central nervous system (CNS) and are particularly effective against cancer that has spread to the brain. This is important because some oncogene-driven lung cancers have a significant tendency to develop brain metastases.

In certain situations, targeted therapy may also be combined with chemotherapy or antibody-based treatments to improve

disease control and outcomes.

Interestingly, although immunotherapy has revolutionised the treatment of many forms of lung cancer, it's often less effective in some of these oncogene-driven cancers, particularly cancers driven by alterations such as EGFR or ALK. This makes finding the underlying molecular driver before choosing treatment extremely important.

HOW DO WE FIND THESE MUTATIONS?

The best way to look comprehensively for these genetic alterations is through next-generation sequencing (NGS).

NGS allows us to analyse the DNA and RNA within a tumour and search for many different genetic alterations at the same time.

Testing is usually performed on a sample of the tumour obtained during a biopsy or operation. In some situations, we can also analyse fragments of tumour DNA circulating in the bloodstream through what is commonly called a liquid biopsy.

Modern comprehensive molecular testing is therefore an essential part of managing many patients with lung adenocarcinoma, particularly those who have never smoked.

Finding the correct mutation can completely change the treatment we offer.

THE MOST IMPORTANT MESSAGE

Perhaps the greatest misconception surrounding lung cancer is that it's exclusively a smoker's disease. It's not.

People who have never smoked can and do develop lung cancer. Because they may be younger, otherwise healthy, and lack the traditional risk factors, their symptoms can sometimes be overlooked or attributed to more common conditions.

Persistent or unexplained respiratory symptoms therefore deserve appropriate investigation, regardless of smoking history.

At the same time, advances in molecular testing and targeted therapies have transformed our understanding and treatment of these cancers. For many patients, identifying the particular genetic alteration driving their cancer allows us to select highly effective, personalised treatments.

Lung cancer doesn't always have a smoking history, and recognising that fact can lead to earlier diagnosis, appropriate molecular testing, and better treatment. 

To view references, visit oncologybuddies.com



MEET THE EXPERT

Dr Ronwyn van Eeden is a specialist physician and medical oncologist in Rosebank, Johannesburg. She has a special interest in lung cancer, breast cancer, immuno-oncology, and precision medicine.

For lung cancer, she currently serves as associate editor on the editorial board for the *Journal of Thoracic Oncology*. Furthermore, she is part of the Africa steering committee for lung cancer for the International Association of Studies for Lung Cancer and previous co-chair for the first Pan Africa Congress for Lung Cancer.

She also steers multi-disciplinary care meetings for patients with lung cancer and will present on awareness and advocacy for patients with lung cancer in Africa at the World Conference for Lung Cancer.



New technology helps target radiation more precisely

The Wits Donald Gordon Radiation Oncology Unit installs sub-Saharan Africa's first full Brainlab ExacTrac Dynamic® device.

When a tumour is small or lies close to healthy tissue or a sensitive organ, there is very little room for error. Radiation must reach the area being treated while limiting unnecessary exposure to surrounding tissue.

The Wits Donald Gordon Radiation Oncology Unit, located at the Wits University Donald Gordon Medical Centre in Parktown, Johannesburg, has become the first centre in sub-Saharan Africa to install the full Brainlab ExacTrac Dynamic® device.

The technology helps the radiation therapy team position and monitor a patient with high accuracy before and during treatment. This is particularly important when treating small, complex, or difficult-to-reach tumours.

WATCHING FOR MOVEMENT DURING TREATMENT

Patients can move slightly during radiation treatment, sometimes without realising it. Tumours in areas such as the chest and abdomen may also be affected by normal breathing.

ExacTrac Dynamic® uses cameras to monitor the patient's surface and low-dose X-ray images to check the position of internal anatomy. It compares this information with the position set out in the patient's treatment plan.

If the patient moves beyond the limits set by the treatment team, the radiation beam can be paused. The team can then check and correct the patient's position before treatment continues.

For patients, this provides an additional layer of monitoring and helps the clinical team keep the radiation closely aligned with the intended treatment area.

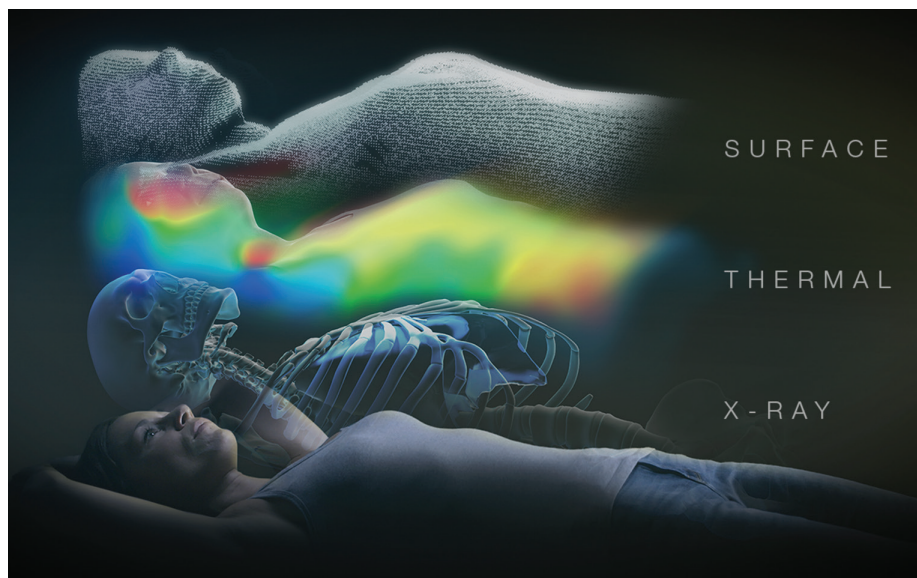
WHAT DOES THIS MEAN FOR PATIENTS?

The technology provides:

- Careful positioning before radiation treatment begins.
- Continuous monitoring during the treatment session.
- The ability to pause the radiation beam if the patient's position changes.
- Added precision when treating tumours close to healthy tissue or sensitive organs.
- Advanced support for selected tumours affected by breathing or other movement.



The device is particularly important for patients receiving stereotactic treatments. Stereotactic radiosurgery delivers concentrated radiation to small, precisely defined targets in the brain. Stereotactic body radiation therapy uses the same highly focused approach for tumours elsewhere in the body. In both, accurate positioning is critical to protect nearby healthy tissue.



Every patient deserves access to safe, advanced cancer treatment, says Tamlyn Abbott, General Manager of the Wits Donald Gordon Radiation Oncology Unit.



She continues, "This device gives our team another way to check a patient's position throughout treatment and respond if it changes. For patients, that means greater confidence that the radiation is being delivered as closely as possible to the area their doctors have planned."

TECHNOLOGY SUPPORTED BY A SPECIALIST TEAM

The ExacTrac Dynamic® device works alongside the Unit's Varian TrueBeam linear accelerator, which delivers the radiation treatment.

It also complements Brainlab Elements Radiosurgery Solutions, which are indication-specific treatment planning workflows. They combine software applications for accurate image co-registration, automated contouring of tumours and organs at risk, consistent

radiosurgery planning, and efficient treatment delivery—all designed to support precise treatment while helping to minimise toxicity. Together, these technologies connect the patient's treatment plan with positioning and monitoring during delivery.

The technology is one part of a much larger clinical process. A multi-disciplinary team of a radiation oncologist, medical physicists, dosimetrists, and radiation therapists manages every patient at the Wits Donald Gordon Radiation Oncology Unit.

The team develops an individual treatment plan based on the patient's diagnosis, the tumour's location and characteristics, and the healthy tissue and sensitive structures around it. The Unit also works closely with referring doctors throughout the patient's treatment.

ABOUT THE WITS DONALD GORDON RADIATION ONCOLOGY UNIT

The Wits Donald Gordon Radiation Oncology Unit provides specialised radiation therapy at the Wits University Donald Gordon Medical Centre in Parktown, Johannesburg.



What's new in prostate and pancreatic cancer treatment?

Dr Daleen Geldenhuys updates us on the latest breakthroughs in prostate and pancreatic cancer treatment presented at the 2026 ASCO Annual Meeting.



ABOUT ASCO

The American Society of Clinical Oncology (ASCO) is the world's leading professional organisation for physicians and oncology professionals caring for people with cancer. The 2026 ASCO Annual Meeting took place in Chicago, Illinois from 29 May to 2 June.

PROSTATE CANCER TREATMENT

Groundbreaking and practice-changing results are kept for the plenary session. This year ASCO didn't disappoint, and the final results of the Phase 3 PROTEUS trial was presented. The anti-cancer medication, apalutamide, is already available and unlike other trials presented at the meeting, with the right motivation, this could change the lives of prostate cancer patients now.

Prostate cancer patients are stratified into certain risk categories (low, intermediate, and high risk) at the time of diagnosis.

The treatment for patients with high-risk prostate cancer is a radical prostatectomy but relapse occurs within five years in 50% of patients.

TRIAL OBJECTIVE

The Phase 3 PROTEUS trial evaluated the addition of apalutamide (oral androgen receptor blocker) plus androgen deprivation therapy (ADT) given before and after radical prostatectomy for high-risk localised or locally advanced prostate cancer.

There were dual endpoints; the one being complete disappearance of the cancer in the prostate when the surgery was performed.

Standard of care at the present time is surgery alone. The trial compared ADT (GnRH analogues/injections to prevent testosterone production) as a control arm. The trialists believed patients wouldn't agree to a trial where they may not receive any

therapy at all except for the prostatectomy, therefore the control arm had to offer treatment other than just observation.

THE TRIAL DESIGN

Patients were randomised into two groups. One group receiving ADT and apalutamide for six months prior to surgery versus ADT alone, followed by surgery and then completing another six months with the same protocol in the adjuvant setting.

The trial was designed to answer the question: Did the combination therapy improve the pathological outcome where there was no cancer cells detected at the time of removal of the prostate?

This endpoint was reached: 8.9% of patients had no detectable cancer and another 30.6% had tumour smaller than an ypT2. This indicates that after undergoing hormone therapy, the tumour has either

completely disappeared or is microscopic, with no cancer found in the surgical specimen.

Secondary endpoint: The five-year metastases survival was 78.2% in the combination arm and 73.5% in the control arm (ADT) alone, compared to 50% as mentioned.

Recovery of testosterone levels after completion of the therapy was around 80% at eight months.

The reality is that patients who relapse will receive ADT lifelong and this trial with limited duration of therapy will ensure that more men will enjoy relapse-free survival.

ALWAYS ASK ABOUT NEW TREATMENT REGIMENS

Patients should always feel free to ask what is new in the treatment of their cancers. Valuable research is done with the patient in mind. Always feel free to discuss news articles and other information with your practitioner. The results and trial data of the PROTEUS study is available online.

PANCREATIC CANCER TREATMENT

Known as one of the deadliest cancers, pancreatic cancer often presents with little warning that something may be wrong, with no active protocols in place to identify who is at risk and no screening tests in place to find the cancer at an early stage. Even when caught early, the outcome is still devastating.

The plenary session at ASCO received a standing ovation from the large oncology community who attended the conference and news spread fast around the globe about a new treatment. An oral targeted medication, daraxonrasib, promises to make a difference in overall survival.

All cancers have different pathways and oncologists often ask for next-generation sequencing (NGS) testing. NGS is an advanced laboratory method that scans a tumour's DNA or RNA for hundreds of genetic mutations at once. This comprehensive genomic profiling helps doctors identify actionable targets for personalised cancer treatments. We have been struggling to find a RAS target that will treat more mutations.

DARAXONRASIB

Daraxonrasib is an oral RAS inhibitor of mutant and wild-type RAS. It has improved overall survival and progression-free survival in RAS mutant pancreas cancer patients, but also in the entire trial group which included RAS wild-type.

Compared to chemotherapy of choice in the control arm, daraxonrasib improved median overall survival to 13.2 months versus 6.7 months (chemo group) and median progression free survival to 7.3 months versus 3.5 months (chemo group).

The treatment was second line. In other words, the patients received prior

chemotherapy and progressed on the treatment before being allowed to participate in this trial.

SIDE EFFECT PROFILE

High incidence of cutaneous side effects, such as a rash and sore mouth. Diarrhoea, nausea, and vomiting are common, but these side effects were usually graded as 1 or 2. It has a lower incidence of Grade 3 adverse events compared to chemotherapy.

This is the first anti-RAS treatment that isn't limited to a specific mutation and seems to be effective whether the mutation is present or not.

This is a giant step in the treatment of pancreas cancer. Our challenge is to fast-track the medication through regulatory authorities, make the medication available, affordable, and to manage the side effects in an acceptable manner.



MEET THE EXPERT

Dr Daleen Geldenhuys is a specialist physician and medical oncologist who works at West Rand Oncology Centre at Flora Clinic and the ICON Unit at Johannesburg Surgical Hospital. She treats patients with all types of cancer and enjoys clinical research, and is a member of SASMO, SASTECS, ESMO and ENETS.

Image by supplied

Clinical Trials

What are they really all about?

"You may qualify for a clinical trial."

If you or a loved one is living with cancer, those words might bring up a few questions. What exactly does that mean? Is it safe? And is it something I should consider?

Let's take some of the mystery out of it...



So what exactly is a clinical trial?

Put simply, it's how researchers learn whether **new ways of preventing, diagnosing or treating cancer** can make a difference.

A trial might look at a completely new treatment, a new combination of existing treatments, or a different way of using a treatment we already know.



Did you know?

Many of the cancer treatments used today were once investigated in clinical trials.



But are clinical trials safe?

That's often one of the first questions people ask — and understandably so.

Clinical trials are carefully planned and follow strict ethical, regulatory and safety requirements. Before taking part, you'll receive information about what's involved, including potential risks and benefits.

Participation is voluntary, and you can choose to withdraw at any time.

Not every trial is suitable for every person. Each study has specific criteria to determine who may be eligible.



Questions to ask:

- What is the study investigating?
- What are the possible risks?
- What will participation involve?
- How often will I need to visit?

Could a clinical trial be an option?

For some eligible patients, a clinical trial may provide access to treatments that aren't yet routinely available. But taking part is always a personal decision, and a trial isn't necessarily right for everyone.

WCR Parktown and Baragwanath conduct oncology clinical trials across a range of cancer types, including breast, lung, prostate, colorectal, cervical, melanoma and haematological cancers.

Curious whether a clinical trial could be an option? Start by asking. Speak to your oncologist or reach out to our research team to find out more.



Scan the QR code to visit our website www.emin8.africa

Prostate cancer screening

Dr Mia Hugo educates us on the age at which men should start prostate cancer screening.

Prostate cancer represents a significant spectrum of disease, ranging from non-aggressive, slow-growing tumours to highly-aggressive disease with a high risk of metastases.

After skin cancer, it's the most diagnosed cancer in males globally. Since there are often no symptoms in its early stages, screening is the primary tool for early detection. However, deciding exactly when and who to screen requires balancing the benefits of catching aggressive cancers early against the risks of overdiagnosing and overtreating slow-growing tumours.

THE PARADIGM OF SHARED DECISION-MAKING

Historically, widespread prostate-specific antigen (PSA) screening led to a dramatic downward trend in prostate cancer stage at diagnosis, reducing mortality but inadvertently causing high rates of overtreatment.¹

Today, local and international guidelines emphasise that screening must be rooted in informed, patient-based shared decision-making.

The foundational principle is that screening should be offered to healthy individuals only after a thorough discussion of the potential harms and benefits. Furthermore, South African and international guidelines all agree that screening is generally inappropriate for individuals with a life expectancy of less than 10 years.^{1,2,3}

THE LOCAL APPROACH: SOUTH AFRICAN GUIDELINES

South Africa faces a distinct demographic reality: prostate cancer disproportionately affects Black African men, who tend to develop the disease at younger ages. Consequently, local guidelines utilise a risk-stratified approach to determine the appropriate age to initiate screening.

According to South African guidelines, informed patient-based screening is recommended in males with a life expectancy of more than 10 years in the following situations:³

- **High risk (Age 40):** Screening is initiated at age 40 for Black African patients and for individuals with a positive family history of

prostate and/or breast cancer in a first-degree relative.

- **Average risk (Age 45):** Baseline PSA testing is recommended starting at age 45 for all other males.

In addition, patients with a history of lower urinary tract symptoms (LUTS) and/or a clinical suspicion of prostate cancer should have their PSA tested regardless of their age group.

INTERNATIONAL PERSPECTIVE

The European Association of Urology (EAU) strongly advocates for a risk-adapted strategy based on individualised life expectancy and baseline PSA values to dictate screening intervals.² Their age-based recommendations are:

- **Average risk (Age 50):** Baseline PSA testing should commence at age 50.
- **High risk (Age 45):** Screening should begin at age 45 for men of African descent and those with a positive family history of prostate cancer.
- **Genetic risk (Age 40):** Screening should begin at age 40 for men carrying known BRCA2 mutations.

The National Comprehensive Cancer Network (NCCN) gives a USA perspective and the 2026 guidelines notes a concerning recent increase in the incidence of metastatic disease in individuals under 55 years of age, particularly in Black/African American men. Their key age-based recommendations lean slightly earlier than the EAU, aligning closer to South Africa:

- **Average risk (Age 45):** Initiate informed testing at age 45.
- **High risk (Age 40):** Initiate shared decision-making at age 40 for those of African ancestry, those with germline variants linked to prostate cancer (BRCA1/2), and those with a concerning family history.
- **Discontinuation (Age 75+):** Continuing screening beyond age 75 should be done only on an individualised basis considering the risks and benefits of testing, treatment, co-morbidities, and life expectancy.

DIGITAL RECTAL EXAMINATION (DRE)

A DRE is when a doctor inserts a gloved, lubricated finger into the rectum to feel the prostate. Including a DRE as part of prostate cancer screening is controversial as a DRE only examines the posterior aspect of the prostate (although this is where most cancers occur) and may miss anterior or small tumours in the early stages of the disease that the PSA will pick up.

It's not a very sensitive test which is why some guidelines no longer recommend DRE as a primary screening test for prostate cancer. It's also dependent on the experience of the doctor doing the examination. In combination with a PSA blood test and done by an experienced professional, it may increase prostate cancer detection, but it's best to consider this on an individual basis depending on patient symptoms and risk factors.⁴

SCREENING INTERVALS

Screening intervals are dictated by the patient's underlying risk – whether high risk or average risk and the initial screening PSA. Depending on initial risk, PSA can be repeated every one to two years and in some low-risk cases even up to 2-4 yearly.¹ In South Africa the general recommendation would be 1-2 yearly.

INVESTIGATIONS FOLLOWING SCREENING

A focused urological history and clinical examination form the basis of all assessments in the South African context. Both the EAU and NCCN strongly recommend the use of multi-parametric MRI (mpMRI) prior to a prostate biopsy to avoid unnecessary procedures.^{1,2}

If a mpMRI reveals suspicious lesions, an image-guided targeted biopsy (often combined with a systematic regional biopsy) is the preferred standard of care. This imaging-first approach preserves the diagnostic lead time while significantly minimising the detection of indolent disease.

CONCLUSION

The decision of when to start prostate cancer screening is dependent on individual risk factors. Average-risk men should initiate screening conversations between ages 45 and 50, while high-risk men, particularly those of African descent or with a strong family history, should begin as early as age 40.

By integrating robust clinical evaluations with advanced diagnostic pathways like pre-biopsy mpMRI, practitioners can maximise the detection of treatable disease while minimising the burden of overdiagnosis. 

To view references, visit oncologybuddies.com



MEET THE EXPERT

Dr Mia Hugo is a radiation oncologist in private practice. She participates in weekly multi-disciplinary oncology team meetings for breast, urology, gastrointestinal, gynaecological, and head and neck cancers. She provides radiation to patients at Wits Donald Gordon, Netcare Milpark, Pinehaven and Olivedale hospitals, as well as at Busamed and 200 Rivonia Medical Centre.

GENERATIONAL COMMUNICATION IN ONCOLOGY NURSING

Amesha Manilall advocates for oncology nurses to adapt their communication to different generations when interacting with patients.

In oncology, a single communication breakdown can completely derail a patient's treatment journey. We often talk about precision medicine, but what about precision communication?

Clinical communication is a life-saving intervention that directly lessens emotional distress, drives treatment adherence, and guards patient safety. However, a one-size-fits-all approach fails a critical variable: the generational lifespan.

To deliver true patient-centred care, nurses must understand the cultural and technological environments of our patients' formative years, adapting our language to the exact generation sitting in our treatment chairs.

THE GENERATIONAL LIFESPAN: CARE STRATEGIES AND PROFILES

- **The silent generation (1928–1945): resilient traditionalists**
 - **Profile:** Deeply respectful of formal hierarchy and discipline, they are naturally polite and stoic.
 - **Challenge:** They frequently mask severe pain, terrified of becoming a burden to their families.
 - **Strategy:** Address them formally (Mr/Mrs/Ms). Provide structured written summaries and use the teach-back method gently to confirm understanding with dignity.
- **Baby boomers (1946–1964): optimistic partners**
 - **Profile:** Boomers value professional authority but demand personal autonomy and conversational interaction.
 - **Strategy:** Avoid rigid lectures. Engage them in open, collaborative dialogue where they actively participate in shared decision-making.
- **Generation X (1965–1980): pragmatic realists**
 - **Profile:** Independent and naturally sceptical, Gen Xers have zero tolerance for fluff.
 - **Strategy:** Give them raw data, explicit timelines, and immediate, functional symptom management that helps them preserve their work and domestic routines.
- **Millennials (1981–1996): digital collaborators**
 - **Profile:** Collaborative digital natives who view care through a relationship-focused lens.
 - **Strategy:** Never dismiss their internet research. Validate their findings, offer digital evidence-based resources, and align therapy with their long-term lifestyle and career goals.
- **Generation Z (1997–2012): authentic visualists**
 - **Profile:** Hyper-connected and highly sensitive to mental health, they process data rapidly but demand authenticity.
 - **Strategy:** Use visual first communication like short videos or graphics. Integrate frequent, intentional emotional check-ins to anchor them through clinical anxiety.
- **Generation Alpha (2013–present): immersive tech children**
 - **Profile:** Raised in an entirely interactive, futuristic digital landscape.
 - **Strategy:** Focus on play-based, family-centred care using gamified digital tools, while keeping parents central to every conversation.

ALIGNING FRAMEWORKS WITH PRACTICE STANDARDS

By aligning workflows with the Oncology Nursing Society (ONS) standards, nurses can systematically map these generational adaptations into concrete daily clinical applications:

ONS standard domain	Requirement	Generational adaptation & clinical application
Patient education	Provide tailored, age-appropriate learning.	Traditional printed booklets (silent) vs interactive video tools (Gen Z).
Psychosocial care	Screen for and manage distress.	Validating professional career loss (millennial) vs extracting hidden pain (silent).
Family-centered care	Integrate family into decision-making.	Active parental co-management (alpha) vs strict individual consent boundaries (silent).
Decision-making	Facilitate shared decision support.	Immersive conversational collaboration (boomer) vs efficient data points (Gen X).



CLINICAL CASE SCENARIOS: COMMUNICATION IN ACTION

- **The Gen X sceptic:** When a patient demands, "Just give me the raw numbers. When can I get back to work?", avoid abstract consolations. Present clear toxicity percentages and practical side effect protocols to maintain their functional independence.
- **The silent stoic:** When an elderly patient claims, "I'm completely fine, nurse. Don't call my son, I don't want to be a bother", recognise it as a mask. Avoid vague questions. Instead, frame your check-ins as a mandatory professional clinical protocol to immediately lift their guilt of being a burden.

FINAL THOUGHT

By dynamically shifting language and tools across the lifespan, oncology nurses can breakdown communication barriers, maximise safety, and deliver deeply humanised, elite-tier clinical care.



MEET THE EXPERT

Amesha Manilall has over two decades of experience in oncology nursing and currently serves as practice manager at Durban Cancer Centre. She previously held roles as nursing manager and research study co-ordinator at The Oncology Centre. A graduate of the University of KwaZulu-Natal, she has specialised training in Oncology and Palliative Care Nursing. She is passionate about patient advocacy, compassionate care, and improving the patient experience.

Entering your new reality

Pieter le Roux, a cancer survivor and counsellor, shares helpful advice on navigating your reality after cancer.



What happens in life after cancer? What does life look like after this profound journey? Is it possible to go on with life exactly as it was before?

This year marks exactly 12 years since my cancer treatment and bone marrow transplant. I can tell you with absolute honesty that my life changed profoundly after that.

To put it into perspective, imagine the cancer experience as a massive, multi-layered burger. It has the bun, patty, garnish, and for some, it's a towering double or triple burger. You can't realistically shove that entire burger into your mouth, swallow it in one single gulp, and then wipe your hands as if nothing happened.

No one would expect you to do that with a physical meal, so why is it expected when processing the immense trauma of going through cancer? I've heard how often people are told, *You have gotten a second chance, just go on with your life.* Yet, you're still sitting with an experience that is incredibly real, intense, and monumental. You can't swallow it whole; you need time to digest it, bite by bite and layer by layer.

ENTERING A NEW REALITY

What you experience post-cancer isn't going back to your old life. It's entering an emerging reality. It's entirely new, much like bringing home a firstborn child. You don't have all the answers or all the knowledge right away, and that is perfectly okay.

It's unknown, and while that can be daunting, it's also an invitation to accept this chapter as something new, and to take the pressure off yourself to have it all figured out. Just as a new baby takes time to grow, your new way of living emerges as you go along. You'll discover different parts of yourself

living in entirely new ways. Part of this emergence is accepting that things will not be the same. The process is organic, revealing itself step by step on your journey.

Most importantly, this is your new reality. Very often, we hear other people's stories and experiences, and the expectation is that your journey should mirror theirs. It shouldn't. This is your unique reality, and it's about learning to live out that specific, authentic part of yourself.

HELPFUL ADVICE

Here are practical steps I found helpful in my own journey:

- 1 First and foremost, give yourself time. Time to work through the trauma of what happened to you. Time for your mind to clear. And time to truly digest the multi-layered burger that was placed on your plate. This isn't a cliché case of "Time heals all wounds." Rather, this is about deliberately allowing yourself the time required to find your own new, unique way forward.
- 2 Move toward accepting that things will be different. They must be. Your perspective has shifted completely. Your way of thinking, everything you felt and experienced, has deeply impacted you. And let's not forget the immense changes your body went through. True acceptance takes time.
- 3 It also means allowing yourself to enjoy life again. Not just the grand milestones, but the small, everyday moments. You are allowed to relish simple things: time spent with family and friends, a good dinner, or simply sitting in the sun and enjoying nature again. Crucially, allow yourself to do this without feeling guilty that others didn't get that same second chance.
- 4 Even if you had a wonderful support system, cancer is still an intensely personal and often lonely journey. As you move forward, allow yourself to actively re-engage with others. That might include talking to a counsellor or a therapist to help you digest everything and gain perspective on your new reality. It's also about celebrating the path you have walked with your loved ones, reaffirming those connections, and embracing life together.
- 5 Lastly, celebrate what you achieved. I spoke to a survivor who said his treatment was the Everest that he climbed. For you, it might be an image like running a marathon or surviving a tough boxing match. The point is, you did it, and you overcame it. Own your achievement and celebrate yourself for what you did. By acknowledging it, you are allowing this new reality to emerge, and you now can fully step into your new life.



MEET THE EXPERT

Pieter le Roux, a counsellor with more than a decade of experience in the oncology field, is the founder of Pivot Point Cancer Support. He is dedicated to providing specialised psychosocial care, helping both patients and their families navigate the emotional and practical challenges of a cancer diagnosis.



My mental health is doing its best...please clap

Bonni Suckling reflects on mental health after grief.

It was only days after my son died from brain cancer when the sentences started arriving. "He's in a better place." "He wouldn't want you to be sad." "He has gained his angel wings." And my personal favourite: "God only picks the nicest flowers for His garden."

Please don't. Just don't.

If you have ever grieved someone you love, you probably have your own collection. Words offered with the best intentions that somehow landed in exactly the wrong place.

My child had just died. I didn't want him to have wings. He was a boy, not an angel. Someone edited a photo of him, added wings and a halo, and posted it all over social media. I was horrified. Nooooo! My beautiful curly-haired boy looked like a little fly, with snow white teeth and a UFO parked above his head. Why? Just why?

I didn't want him to be a nice flower in God's garden either. My completely inappropriate internal response was, *Well, thank God you have weeds, so you get to keep yours*. Grief doesn't always bring out our most socially acceptable thoughts.

And I definitely didn't want to hear that he was in a better place. I believe in Heaven. I believe my son is with God. But at that moment, with all due respect to Heaven, I wanted him in my place. Preferably making a mess, irritating me, and very much alive.

WORDS THAT CUT DEEPER

I have heard versions of this on repeat, "If my child died, I could never continue living. I would die too." That one lands differently. Does the fact that I survived my son's death mean I loved him less? Because now, apparently, I have to feel guilty for breathing too. Most people mean well. Watching someone suffer is uncomfortable, so we reach into our pockets and pull out any old words.

THEN TIME PASSES

The Woolies lasagne stops arriving. The phone stops pinging. People go back to work, school runs, and deciding what's for dinner. And there you are. Still grieving. There are potholes and load shedding to discuss now. Life has returned to ordinary things, and somehow the person still taking up every inch of your heart is expected to take up less space in the conversation.

Maybe you know that feeling. That quiet pressure to start looking a little more...normal. Cheer up. Be grateful. Think positively. Move forward. Move on. You're taking too long. Fifteen years later, I still grieve my son. Like, a lot. My grief never came with an expiry date. Dammit.

THEN COMES THE SILVER LINING

"But look at all the good that came from his death." For me, that is Rainbows and Smiles, the childhood cancer foundation created in my son's memory, my studies and my work in paediatric palliative care. I understand what people mean. Something meaningful grew from something devastating. But the price will always be too high.

I would hand it all back to have my son. Those things came after Jed died. They didn't happen because he needed to die. There is a difference.

Maybe your loss changed you too. Perhaps you became stronger, kinder, or braver. You're allowed to be proud of who you became without being grateful for what broke you. I found meaning in what I chose to do with the life I had left.

And here is where grief gets complicated. After years of everyone wanting you to be okay, slowly, quietly, you realise that sometimes you are. You laugh. Properly laugh. The kind where your stomach hurts and you almost pee a little. You go on holiday and have all the fun.

You fall in love with a gorgeous man who gives you that ridiculous fuzzy feeling in your tummy, makes you laugh, grounds you and, annoyingly, looks particularly good while doing it.

Wait. That happened to me. I digress. This is my grief article, not a Mills & Boon. Give me another 750 words and we can discuss him properly.

YOU FEEL HAPPY

Then one morning you wake up and realise something almost frightening. You feel happy. Not I'm fine, thanks happy. Actually happy.

I have learnt that I can love my life and still desperately wish Jed hadn't died. Those two truths can sit beside each other. And yours can too. Your happiness isn't betrayal. Your laughter isn't forgetting. You don't have to stay broken to prove that your person mattered.

Maybe mental health after loss isn't about getting back to who you were before. Maybe it's learning that you're allowed to keep living. My mental health is doing its best.

So, when happiness finds you again, don't push it away. Let it in. Laugh loudly. Love deeply. Live fully.

You aren't leaving your person behind. You're carrying their love forward. 



MEET THE EXPERT

Bonni Suckling is the founder of Rainbows and Smiles Foundation. In 2022, she completed her Paediatric Post Grad Diploma, a testament to her dedication to improving paediatric healthcare. She has played a pivotal role in establishing paediatric palliative care support groups, offering solace and guidance to families. She is also a gym instructor and endurance athlete.

The power of small wins

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Dr Andrew Robson unpacks what animal rehabilitation can teach about determination, highlighting the power of small wins.

In medicine, recovery rarely happens all at once. It happens in small, almost unremarkable moments. For example, a dog placing weight on a leg for the first time after surgery, a cat managing to groom itself again after illness, a hesitant step that becomes two, then three. These are the milestones we celebrate quietly in the consult room, knowing how much effort sits behind them.

The recovery progress can feel frustratingly slow and is often not linear. There are good days, setbacks, and plateaus. It's easy to become focused on the end goal: remission, strength, a return to normal. But that focus can sometimes obscure the quiet progress happening along the way. There is also a psychological dimension to this. When progress is defined only by large outcomes, it can feel distant and discouraging. When progress is measured in smaller, tangible steps, it becomes visible and immediate.

SMALL WINS GIVE A SENSE OF FORWARD MOVEMENT

Rehabilitation should be built on small wins. And in many ways, these small victories tell us more about determination than any dramatic comeback ever could. Unlike people, animals don't measure their progress by what they have lost. A dog recovering from spinal surgery doesn't dwell on how far it used to run. It responds only to

what its body can do today. If today that means standing for a few seconds longer than yesterday, that is enough. There is something profoundly instructive in this. Animals don't question whether the progress is enough, they simply continue.

I often try guide owners through this process. I ask them to celebrate the small changes, things like improved appetite, a brighter demeanour, a slightly stronger step. These markers may seem minor, but they are often the most reliable indicators that healing is underway.

The same principle should apply in human health. Small wins matter because they are achievable. They create momentum and offer proof that the body is responding, adapting, and rebuilding. And perhaps most importantly, small wins provide something that can feel in short supply during illness, a sense of forward movement.

Animals, in their simplicity, demonstrate this beautifully. They don't become overwhelmed by the scale of recovery. They engage with the present moment, responding to encouragement, routine, and care. Their determination isn't loud or dramatic. It's steady, consistent, and quietly resilient.

CHOOSING TO SEE THE SMALL WINS

Of course, this isn't to suggest that human experiences of illness can be

reduced to the same simplicity. People carry fear, uncertainty, and the weight of expectations in a way that animals don't. But perhaps that is exactly why there is something to learn here. We, humans, can choose, even in difficult circumstances, to notice the small wins.

For my mom, who had breast cancer, this was being able to get out of bed and make herself a cup of coffee, her first time enjoying her dinner and finishing the meal, and a day with less pain than yesterday.

Towards the end of the journey when exhaustion and burnout is at its highest, this can even be the appointment that went better than expected. These moments may not feel significant on their own, but they are the building blocks of recovery.

In my clinic, we often see the moment an owner realises this and their focus shifts. Instead of waiting for a dramatic improvement, they begin to recognise progress as it happens. The journey feels less overwhelming, more manageable. And in many cases, that shift makes all the difference. Determination isn't always about pushing harder or faster, despite what society wants you to think. It's not about the 4am cold plunges or the hustle culture. It's simply about continuing, one foot in front of the other, step by step, day by day and allowing those small steps to accumulate into something meaningful. 

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Be kind to yourself, celebrate even the smallest wins and try not to measure your success by what you've lost.

MEET THE EXPERT



Dr Andrew Robson is a veterinarian with a Master of Science degree from Wits University. Based in Johannesburg, Andrew provides the highest standard of care to small animal patients and their families. With a strong interest in companion animal medicine, animal physiology, and client education, he is passionate about strengthening the human-animal bond and supporting pet parents through evidence-based, compassionate veterinary care.