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THE HIDDEN GEM in the Land of Gems

A Harvard-trained human rights lawyer is opening Botswana's doors to the biomedical industry

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Breaking Boundaries in Blood Cancer

Science in Action

The Hidden Gem in the Land of Gems

A Harvard-trained human rights lawyer is opening Botswana's doors to the biomedical industry — and the world should be paying attention

Interview by Gevorg Tamamyan,
the Editor-in-Chief of OncoDaily and World Health Voices

Before I flew to Botswana, I knew four things about the country.

The capital is Gaborone. The population is around 2.5 million. There is a national philosophy called Botho — serving others with humility and respect for persons. And there are diamonds.

That was the extent of it. So I did what I always do before a country I do not know: I read. And the more I read, the more I realized how little the world knows about a place that has quietly become one of the most interesting stories in global health.

A democracy that works

For 58 years, one party governed Botswana. In the last election, the opposition won.

Then something happened that should be ordinary and is not: power transferred. Calmly. Without crisis. The way it happens in the oldest democracies in the world.

The man who won is **President Advocate Duma Boko — a human rights lawyer,** a Harvard alumnus, and a candidate who lost twice before he won on his third attempt. That detail matters more than it looks. Persistence is not a personality trait in politics; it is a strategy. It tells you what a leader does when the result does not go his way.

Botswana is also consistently among the least corrupt countries on the continent, one of the safest, and one of the most beautiful. These are not small things. They are the preconditions for everything else in this article.

"The most candid letter by a sitting leader I have ever read"

Before the trip, while preparing for my meeting with the President, I came across an open letter he had published in The Guardian. I expected a political statement. Instead, I found one of the most candid reflections I have read from a sitting head of state about the failure of his own health system.

In August 2025, Botswana ran out of medicines. Hypertension drugs. Diabetes drugs. Cancer drugs. TB drugs. Dressings and sutures. Elective surgeries were suspended. The President declared a national public health emergency and put the military in charge of distribution.

The cause was not a mystery. Diamond revenues collapsed. Donor funding was cut. A supply chain that had looked solid for decades turned out to be resting on a single commodity price.

What the President wrote about it was this: **patients went without treatment not because health workers failed them, but because the system did.**

I want to sit with that sentence for a moment, because it is the whole argument of my professional life, written by someone else.

The knowledge existed. The medicines existed. The health workers were there, trained and willing. What failed was delivery. What failed was access. What failed was the system that connects a proven therapy to the person who needs it.

This is not a Botswana problem. This is the problem — in oncology, in cardiovascular disease, in every field we cover at OncoDaily. Children with cancer who would have an 85% chance of cure are not dying because science has failed them. They are dying because they were never diagnosed, or the drug never arrived, or the family went bankrupt trying.

What the President told me

When we met, he did not talk about the crisis as a misfortune. He talked about it as information.

"We need to build a stronger system, and we can. For a long time, as a country, we relied on diamonds. But our real diamonds, our gem, is our people and our country.

Africa must not be left behind. We have 1.5 billion people. We can and must be self-sufficient. It should not be that we rely on medications from outside. We must rely on ours — we must start our own production, we must solve the problem of pharmaceuticals, and we will.

We have the best democracy. Now we must create

The Minister of Health of Botswana Dr. Stephen Modise receives a certificate from WHO Director-General Dr Tedros Adhanom Ghebreyesus. May 2025. WHO/Pierre Albouy

the best healthcare system."

I have heard versions of this sentiment in many capitals. I have rarely heard it with this specificity, or from someone who has just lived through the failure that makes it urgent.

Saturday is for funerals

On the plane, I was reading a book by that title. I got to the middle and had to stop for a while.

It describes a Botswana where HIV was cutting through an entire generation, where weekends were organized around burials, where life expectancy fell below fifty. It is a difficult book, and it is recent history — not ancient history.

And here is what has happened since. Life expectancy has climbed back by roughly two decades. Botswana has advanced to gold-tier status on the path to eliminating mother-to-child transmission of HIV — a distinction very few countries anywhere have earned.

The same country. The same people. One generation.

That is what resilience actually looks like: not the absence of catastrophe, but the capacity to get up afterward. When a country tells me it intends to build the best health system in Africa, I look at its track record before I decide whether to believe it. Botswana's track record is that it has already done something harder.

A small moment at a diplomatic reception

On my last day, there was a diplomatic reception — a farewell for the departing EU Ambassador. I happened to be there. The speeches were genuinely warm, which is rarer at these events than you would think.

But one detail stayed with me. When the Vice President stood to acknowledge the honored guests, he named the leader of the opposition.

Nobody in the room seemed to find this remarkable. I did. I have worked in many countries where that would be unthinkable — where the opposition is an enemy to be managed rather than a part of the nation to be acknowledged.

That is Botho in practice. And I wish more countries would learn this culture.

What Botswana is offering

This is the part I want the industry and academic leaders reading this to understand clearly.

Botswana is not asking for charity. It is opening a door.

In my conversations there, the message was consistent: the country is ready to host pharmaceutical and biomedical production. It is ready to become a regional and global hub for research, development, and clinical trials. It is prepared to support serious partners with tax incentives, with land, with regulatory engagement, and with something harder to manufacture than any of these — political stability, low corruption, rule of law, and a government that answers the phone.

For a company weighing where to establish African manufacturing or research capacity, that combination is not common. Most of the conversation about African pharmaceutical sovereignty focuses on the size of the need. Botswana is offering something more useful: a safe place to start.

The market logic is straightforward. A continent of 1.5 billion people currently imports the overwhelming majority of the medicines it consumes. That dependency was exposed in 2025 in Botswana, and it will be exposed again elsewhere. Whoever builds the local capacity first will not be doing anyone a favor. They will be early.

Why this is our cover story

Three reasons.

First, many of the executives and academic leaders who read OncoDaily are exactly the people who decide where facilities get built and where trials get run. You should know that this opportunity exists, that the need is enormous, and that the welcome is real.

Second, OncoDaily's mission is to be a space for everyone, from everywhere. We have millions of readers across the world. Most of them have never seen Botswana. They should.

Third — and this is why I wrote it myself rather than assigning it — Botswana is now a live test of the argument that many of us have been making for years: that the binding constraint in global health is not knowledge but delivery, access, and equity. A country has said this out loud, from the top, after paying the price for it. If it succeeds, the argument stops being rhetoric and becomes a model. That deserves more than a news item.

The land of gems

The diamonds built Botswana. They funded the schools and the clinics and the roads, and then the price fell and the medicines ran out, and the country learned what it had actually been standing on.

The President is right about where the real gem is. It was never in the ground.

It is in a people who lived through an epidemic that devastated a generation and rebuilt their life expectancy.

In a democracy that handed over power without breaking.

In a Vice President who names the opposition leader among the honored guests. In a head of state who was willing to write down, in a foreign newspaper, that his system failed — and then to say what he intends to do about it.

Botswana is the hidden gem in the land of gems.

The doors are open. I would encourage the industry to walk through them.

P.S. If anyone reading this is interested in exploring this opportunity, please feel free to reach out to me directly, and I would be happy to connect you with the President's team.

Christopher Jackson and the Question Oncology Cannot Avoid

Who Is Progress Really For?

ONCO INFLUENCERS

Interview by Shushan Hovsepyan, MD, SVP of OncoDaily

"We have the power to defy the selfish genes of our birth." — Richard Dawkins, The Selfish Gene

Christopher Jackson was 18 when he read The Selfish Gene. He remembers it as one of the books that shaped the way he learned to think about science. There is something fitting about that choice. The young reader drawn to a book about the forces that shape us became an oncologist increasingly interested in the forces that shape cancer care — and in whether those forces can be changed.

Today, Professor Christopher Jackson, a medical oncologist and co-lead of New Zealand's Cancer National Clinical Network, has helped reshape cancer care far beyond the patients he treats. His work has touched clinical oncology, national cancer policy, quality improvement, advocacy, and the global conversation around Common Sense Oncology. But in his telling, none of this began with policy. It began with patients.

"It was always the patient in the clinic that was the big anchor and the big motivator."

That patient in the clinic — the person waiting too long, diagnosed too late, or unable to access care on equal terms — became the thread running through Jackson's career. It is also the thread running through the question his work keeps asking: when oncology says it is making progress, who is that progress really for?

Medicine Is Not Only About Cures

Jackson did not enter oncology because he was fascinated by one particular cancer or one specific treatment. He was drawn there through people.

He began in general medicine, where he found himself especially interested in communication and in the relationships doctors build with patients. That interest led him toward palliative care and eventually oncology.
It was there, he says, that his understanding of medicine began to change.

"Medicine wasn't just about curing people. It was about being there and being present during suffering."

For a young doctor, that realization mattered. Oncology exposed him to illness that could not always be reversed, and to patients whose needs went far beyond prescriptions or protocols.

"Many people, when they get into medicine when they are youngsters, they have this false idea that medicine is all about cures. But that element of just being there with someone and helping them through a tough time really felt very, very meaningful."

Presence, in other words, became part of the work. But over time, listening closely to patients also revealed something else: many of the hardest problems they were facing were not random failures. They were patterns.

When Individual Stories Reveal Systemic Problems

In clinic after clinic, Jackson began hearing versions of the same story. Patients were diagnosed late. Screening did not reach everyone. Waiting times were too long. Access to oncology specialists and advanced drug therapies varied.

"When I was just listening to my patients coming in, appointment after appointment, new patient after new patient, it became pretty obvious that a lot of the problems they were facing with their diagnosis weren't glitches, they were features."

A single story could be dismissed as an exception. But repetition made that impossible.

"Any one individual patient's story could say, oh, well, that's just a single incident. But actually it was a consistent thing that was happening time and time again."

That realization changed the scale of his work. If the same barriers kept appearing patient after patient, then helping people required more than being a good clinician inside one consultation room.

"If I wanted to help the patients with the problems in the clinic, you had to look more broadly than that and start thinking about systems-based interventions."

That thinking led Jackson and colleagues into healthcare quality, cancer outcomes, and what he calls the "postcode lottery" of cancer care — the way a patient's chance of timely diagnosis, treatment, and survival could depend on who they were and where they lived.

The Patient Who Made the Question Public

Then one patient brought those questions out of research and policy circles and into the public eye.

Blair Vining was a Southland farmer, husband, father of two, and former rugby player and coach. In Jackson's account, Vining was 38 when pain in his calf led to the discovery of a DVT. Further scans revealed pulmonary embolism and

liver metastases. By the time he was referred for specialist care, he had been told there could be a two-month wait.

He came to see Jackson privately and asked the same questions Jackson and colleagues had already been asking through their research.

"Why do people have to wait so long? Why is the system not delivering for people? Why do people living in one part of the country have a different outcome to others?"

Vining's questions were direct because his situation was direct. He did not have the luxury of waiting for a system to gradually become fairer. But he also did not limit the question to himself. His story became a public challenge to the idea that cancer care could vary so sharply within one country.

Jackson describes him as a patient with "an enormous reach with the community," someone who led a public-facing part of the campaign for a national cancer agency.

"That relationship was very influential for me in my journey as an advocate as well."

The force of Vining's advocacy was not only that he told a personal story. It was that his personal story exposed a national structure. The question was no longer whether one patient had been unlucky. The question was whether the system itself was organized in a way that made unfairness predictable.

When Your Postcode Changes Your Cancer Care

The inequities Jackson and collaborators were documenting became known as New Zealand's "postcode lottery" of cancer care. Outcomes varied across the country, with major differences affecting Indigenous and rural New Zealanders and patients living in different regions.

At the time, New Zealand had about five million people and 20 regional authorities responsible for delivering healthcare, alongside a disconnected primary care network.

"We're a country of 5 million people. So having 20 regional authorities for the management of 5 million people was just crazy."

The issue was not only the number of authorities. It was the fragmentation that followed.

"In a small country of 5 million, that meant that the leadership was very diffused and it was very difficult to achieve anything meaningful in terms of structural change or coherence or consistency of care."

Even when hospitals were shown where cancer care was falling behind, there was little national mandate to require change.

"You could do it one hospital at a time, take 20 lifetimes to achieve that, or you could do something fundamental and structural in terms of changing the environment."

Twenty lifetimes were not an option. Structural change was.

But identifying a policy solution was not enough. The harder task was making the problem emotionally and politically impossible to ignore.

"The first challenge, I think, was, as always, hearts and minds."

Jackson and colleagues knew that asking the public to support "a new government bureaucracy" would not move people. Instead, the campaign centered the people already living with the consequences of the system.

"We anchored the story and the experience of the patients and told a story of how people were missing out."

That changed the campaign's emotional center. It was not simply a critique of what was broken. It was an argument for what could be built.

"What we did was we said there's an immediate solution that we can achieve, and that is a solution which is based in fairness and one which is based in hope."

As patients and families shared their experiences, the issue moved beyond academic papers and policy conversations. It entered the public imagination.

"We got that juggernaut rolling. And after a while, the story started to tell itself."

The government was not initially eager to proceed. But the pressure kept building until the idea of a national cancer agency became difficult to resist.

"After a while they saw it was something that the people wanted. And they gave us room to say, yep, okay, fine, get on with it."

A National Agency Meets a Pandemic

For a moment, it seemed the hardest part had been won.

Then, only a few months into establishing the agency, COVID-19 arrived.

The timing could hardly have been more dramatic. New Zealand had just started building a national cancer structure when the pandemic forced the health system to prove whether national coordination could actually work.

Being geographically distant gave the country something valuable: time. New Zealand could watch what was unfolding in Italy, the United States and the United Kingdom, and use those extra weeks to prepare.

"We could see what was happening in other places and get ahead of it a little bit more."

One lesson was already clear: if screening, diagnosis and treatment simply stopped, cancer patients would pay the price later. So while services elsewhere were shutting down or slowing, New Zealand tried to keep cancer care moving.

"We managed to preserve and keep the services open. We managed to make sure that people who had cancer still got their treatments on time."

That required constant communication. National teams met every day — sometimes several times a day — to share what was happening and coordinate decisions.

"We were all paddling in the same direction."

The emergency response became a demonstration of what national leadership could do. It showed that coordination was not bureaucracy for its own sake; it could protect diagnosis, treatment, and continuity of care at precisely the moment a fragmented system might have failed.

After the urgency of the pandemic came the slower work: data systems, quality improvement, cancer genomics, drug access, and national standards. The moment of radical change had passed into the work of implementation.

"We're in a process of evolution rather than revolution." That phrase could describe more than the New Zealand cancer system. It also describes the next part of Jackson's work: not rejecting oncology's progress, but asking whether its direction still reflects the values of the people it is supposed to serve.

When Cancer Progress Starts Looking Like The Emperor's New Clothes

That question is part of what drew Jackson toward Common Sense Oncology. He joined the movement after Professor Chris Booth invited him to its first meeting in Kingston, Ontario, where only around 30 people gathered.

The invitation resonated with him as a New Zealander. Although New Zealand is a high-income country, it has always had to be deliberate about how it spends healthcare resources. From that distance, some global oncology trends looked difficult to justify.

"Sometimes the stuff that goes on in other countries, we look at that and we feel like it's an episode of The Emperor's New Clothes."

The uncomfortable question was whether oncology had become so eager to call something progress that it had stopped asking how much that progress was actually worth to patients.

"Are people really suggesting a $300,000, $400,000, $500,000-a-year therapy which extends people's lives by four and five weeks? Is that really what we need to be doing? Is that really what's important?"

Jackson is careful not to dismiss oncology's real victories. He points to major advances in testicular cancer, lymphomas and leukemias, and to the impact of immunotherapy in melanoma and lung cancer.

Those are genuine successes. His concern is what happens when dramatically smaller gains are described with the same enthusiasm.

"You just can't compare those sorts of changes to these tiny, tiny, tiny gains with horrific toxicities at massive costs in other areas."

Once such numbers leave a conference presentation and enter the clinic, the calculation can look very different. Jackson describes telling patients that a treatment might help them live two or three months longer but cost something close to the value of their family home.

"They would look at me and go, are you crazy? Why would I do that? I want to spend time with my family and do things that matter to me."

Those conversations are difficult to fit neatly into a progression-free survival curve. They involve financial toxicity, treatment toxicity, opportunity costs and time toxicity: time spent travelling, waiting, receiving therapy, managing side effects, and not being elsewhere.

Common Sense Oncology, as Jackson describes it, is an attempt to bring those realities back to the center.

"Oncology in some ways has become a victim of its own success."

The field has become so hungry for faster progress that

it has increasingly accepted surrogate endpoints and shortcuts intended to bring therapies to patients sooner. Sometimes, Jackson argues, those shortcuts leave uncertainty over whether what looks like progress on paper translates into something patients actually feel.

He is not asking oncology to stop moving forward. He is asking it to check its direction.

"We have just floated a little far from our core mission, and it is time just to nudge ourselves back towards that middle ground."

The People and Books Behind the Advocate

Jackson's willingness to ask uncomfortable questions was shaped by people around him as well as by books or institutions. When asked about mentorship, he broadened the idea.

"I think my career has been shaped more by collaborators than mentors."

One early influence was Professor David Cunningham of The Royal Marsden, whom Jackson describes as "one of the clearest thinkers" he has ever met.

"He helped me understand where the top of the mountain was in terms of oncologic research, what could be achieved with excellence, and what world-class care looked like."

Another important collaborator was Professor Diana Sarfati, whose expertise in epidemiology, public health and cancer inequalities complemented what Jackson was seeing in the clinic.

"She had a very deep understanding of epidemiology and of cancer control. I had a very deep understanding of the problems in the clinic that people faced day to day."

That combination — public health evidence and clinical experience — helped turn variation in cancer outcomes into a national policy issue.

Books also gave Jackson language for the scale of change he was trying to understand. Siddhartha Mukherjee's The Emperor of All Maladies helped him think about the long history of cancer and about how doctors, patients and governments can together create a "systems-based juggernaut for change."

The Selfish Gene shaped his scientific thinking when he was 18. A book on Taibi Kahler's Process Communication Method shaped the way he thinks about communication, personality, distress and leadership.

In oncology, he says, communication is not a special event. It is the work.

"In oncology, you're doing communication all day, every day."

The book helped him recognize that different people need different kinds of communication: emotional connection, information and structure, recognition of work, values-based framing, action, or reflection.

"If you're trying to do communication to larger groups, you have to speak in multiple channels at once."

That lesson matters in clinic, in policy, and in advocacy. Changing systems is not only about being right. It is about being understood by different audiences at the same time.

Leadership: A Title, Achievement, or an Opportunity?

The same logic shapes Jackson's view of leadership. For him, leadership is not simply a title, a board seat or a sign of personal achievement. It is an opportunity that becomes meaningful only if it is used.

During his time as Medical Director of the Cancer Society, he saw what positional authority could provide. The organization had enough public trust and standing that when he called a health minister or senior official, there was a good chance they would answer.

But getting the phone answered was not the point. What happened next was the work.

"There's really no point in having a leadership role if you don't do something with it. Simply being on a board, being on a committee, being in a role is meaningless if you don't do something with it."

He is equally skeptical of leaders who need to dominate every room. One leadership lesson stayed with him from a friend in industry.

"If you're a leader and you're the smartest person in the room, then you've done a terrible job."

For Jackson, good leadership means surrounding yourself with people who bring different strengths, perspectives and ideas. It means creating psychological safety, encouraging healthy debate, and allowing disagreement to improve the final decision."*The exchange of ideas and challenge makes everyone better."*

Leadership also changes depending on the stage of an organization. A start-up phase requires one approach; a mature organization requires another. Common Sense Oncology, in its establishment phase, needed a different style from a long-standing global organization such as UICC.

But across all settings, one requirement stays constant.

"As a leader, you must behave with integrity and with respect for the people around you."

Those words sound simple, but Jackson defines them practically.

"All that means is showing up when stuff's tough."

Trust, he adds, is fragile.

"Trust and respect are things that can take you a lifetime to build and a moment to destroy."

The Cost of Doing It All

With a career spanning patient care, research, policy, advocacy and global cancer control, the obvious question is how Jackson protects his time and finds work-life balance.

He rejects the premise.

"I don't really think there's any such thing as work-life balance, actually. I think there's work-life compromise."

When his children were younger, he remembers being at work and feeling like he was not being a good enough father. Then he would go home, spend time with his children, and wonder whether he should be doing more for his patients.

"There was always this wee nagging voice in the back of my head going, you're mucking something up, you're stuffing something up."

Eventually, he let go of the idea that life could be arranged into perfect harmony. There were trade-offs. He could write more papers if he spent more time at work. He could move to a larger center in a bigger country. But each option would cost something.

"That would mean that I wouldn't get to live in paradise overlooking a local beach and walking my dog in the evening."

For Jackson, the key is not eliminating compromise. It is making compromises that fit one's values.
"Hopefully being a better doctor makes me a better human, and being a better dad makes me a better doctor too."

It is another version of the same principle he brings to oncology: every decision has a cost, and values should be visible when those costs are weighed.

Not What You Want to Do. Who You Want to Be.

At the end of the conversation, Jackson's advice to young oncologists is not about publications, titles, leadership roles or reaching "the top of the mountain." It is about character.

"Spend your time thinking about not what you want to do, but who you want to be."

He urges young clinicians to reflect on values and direction rather than rigid destinations. Goals can be useful, but they can also narrow a life too early. Direction, if rooted in values, leaves room for unexpected opportunities.

"If you are rigid about a destination where you're going, then you'll miss the extraordinary opportunity that you never expected that will unfold along the way."

Oncology does not allow much illusion about time. It teaches clinicians, again and again, that life is fragile and that waiting for a future version of oneself can be a dangerous habit.

"You better make sure you're doing what you value now, because you can't be quite sure how many tomorrows there are."

The Selfish Gene stayed with Jackson long after he first picked it up at 18. Decades later, the idea that seems to remain is a more human one: we may be shaped by many forces — biology, systems, geography, institutions, chance — but we still have a say in what we choose to change and who we choose to become.

"Be who you want to be now."

For Jackson, oncology begins with being present beside suffering. It expands into systems when the same suffering repeats in predictable ways. It becomes advocacy when patients ask why the system is not delivering for people like them. It becomes leadership when a title is used for something beyond itself. And it becomes common sense when progress is measured not by how loudly it is announced, but by whether it helps patients live longer, live better, and spend time on what matters most.

"To help the people who you see every day have a fair chance, a fair go, a little bit longer with someone who they love."

article by Eliz Baloyan,
MD, Editor at OncoDaily

GC-OS 2026

Where Cardio-Oncology Looks to the Future

From artificial intelligence and advanced cardiovascular imaging to cardiac amyloidosis, exercise interventions, and the cardiovascular implications of next-generation cancer therapies, **GC-OS 2026** will bring the rapidly evolving field of cardio-oncology into focus this October.

The **International Cardio-Oncology Society (IC-OS)** will host the **2026 Global Cardio-Oncology Summit (GC-OS)** from **October 5 to 7, 2026, in Williamsburg, Virginia, USA,** gathering clinicians, researchers, and specialists working at the intersection of cardiovascular medicine and cancer care.

Under the theme **"Cardio-Oncology Innovation and Implementation for the Future,"** the summit will examine where the science is moving and how emerging knowledge can be translated into everyday clinical practice.

Registration is now open for GC-OS 2026.

A Field Shaped by the Success of Modern Cancer Care

As cancer treatment continues to improve survival, the cardiovascular consequences of cancer and its therapies have become increasingly important to long-term patient care.

Cardio-oncology addresses this intersection by identifying cardiovascular risk before treatment, monitoring patients during therapy, recognizing complications early, and supporting survivors whose cardiovascular needs may continue long after cancer treatment ends.

GC-OS 2026 will bring these priorities together in a multidisciplinary setting, exploring surveillance, prevention, diagnosis, treatment-related cardiovascular complications, and models of care that can be adapted across different healthcare environments.

From Artificial Intelligence to Advanced Imaging

Technology will occupy a prominent place in the 2026 scientific program.

One major focus will be the intersection of **artificial intelligence and cardio-oncology,** including its potential applications in clinical assessment, surveillance, cardiovascular imaging, and future approaches to patient management.

Sessions will also examine **novel surveillance strategies** and the evolving role of integrative and multimodality **imaging in identifying cardiovascular changes, evaluating** treatment-related risk, and guiding clinical decisions throughout the cancer care pathway.

Prevention, Cardiac Amyloidosis, and New Therapies

The program will address **cardiac amyloidosis,** including developments in diagnosis, disease monitoring, treatment selection, and long-term cardiovascular care.

Preventive strategies will also form an important part of the summit, with discussions surrounding **preventive therapies and exercise interventions for cardiotoxicity.** The focus reflects the field's increasing emphasis on identifying cardiovascular risk earlier and considering interventions before complications become clinically significant.

GC-OS 2026 will additionally examine **next-generation therapies in hematology and oncology,** their potential cardiovascular implications, and the clinical strategies needed to support patients receiving increasingly complex treatments.

The relationship between the **immune system, cancer, and cardiovascular disease** will also be explored as understanding of these interconnected biological processes continues to develop.

Building a Global Cardio-Oncology Community

Beyond its scientific program, GC-OS serves as a forum for professional exchange, original research, and international collaboration.

Participants will have opportunities to present their work, discuss emerging clinical questions, exchange experience across specialties, and establish collaborations extending beyond the meeting itself.

The interdisciplinary nature of the summit reflects a field increasingly dependent on cooperation between cardiology, oncology, hematology, imaging, research, and survivorship care.

Leadership From VCU's Cardio-Oncology Community

GC-OS 2026 will be co-chaired by **Wendy Bottinor, MD, MSCI,** Medical Director of Cardio-Oncology at the **VCU Pauley Heart Center,** and **Fadi N. Salloum,** PhD, Senior Associate Dean for Research at the **VCU School of Medicine.**

Dr. Salloum also serves as the **Natalie N. and John R. Congdon Sr. Endowed Chair at the VCU Health Pauley Heart Center.**

The summit is also connected with the **Massey Comprehensive Cancer Center and VCU Health Pauley Heart Center.**

Science Meets History in Williamsburg

The scientific discussions will unfold in Williamsburg, home to **Colonial Williamsburg**, described as the world's largest living history museum, alongside the city's dining, shopping, natural surroundings, and distinctive small-town character.

Recently rated the **"Most Underrated Travel Gem in the U.S.,"** Williamsburg will provide a setting where three days of scientific exchange can extend into professional connections and conversations beyond the conference hall.

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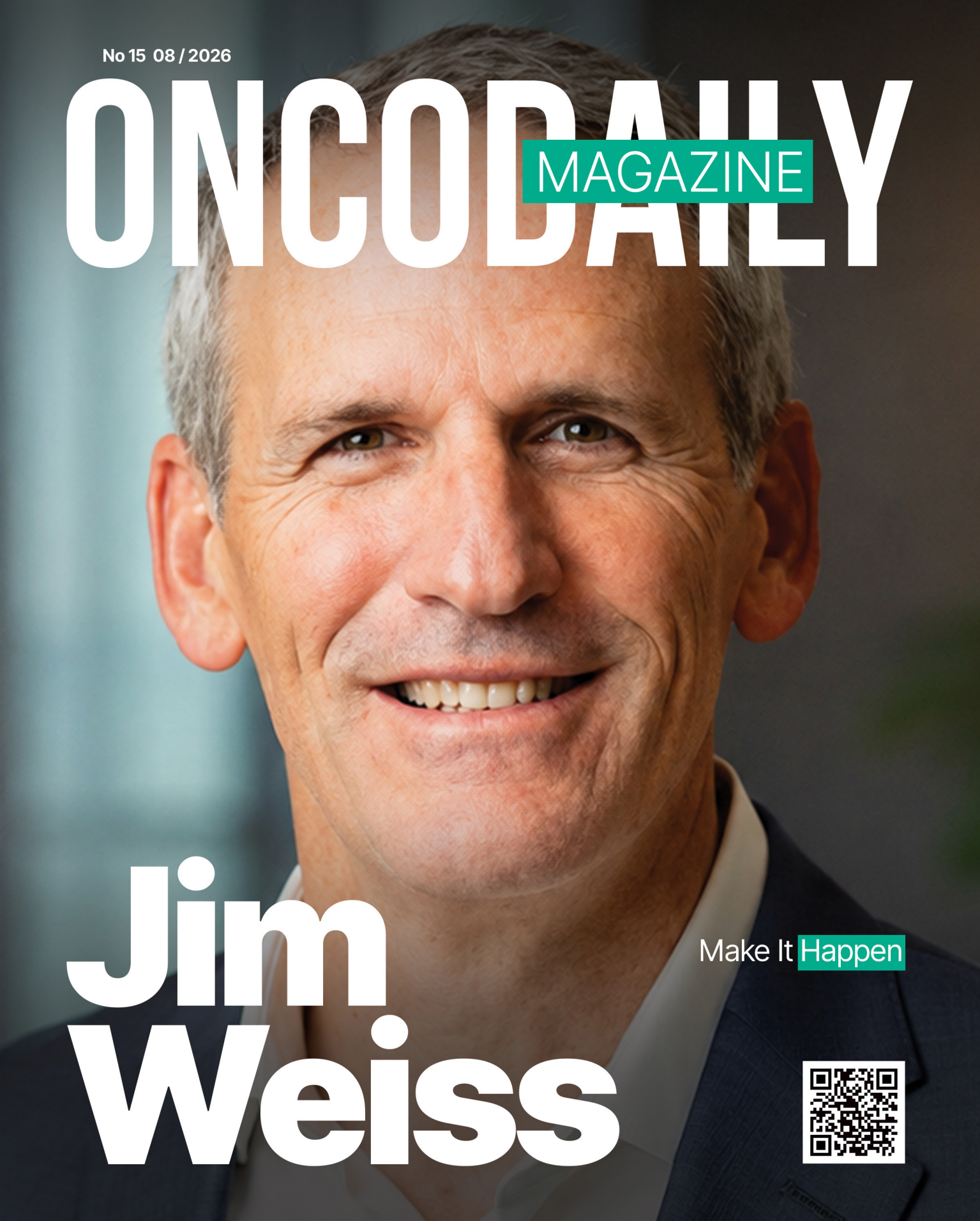
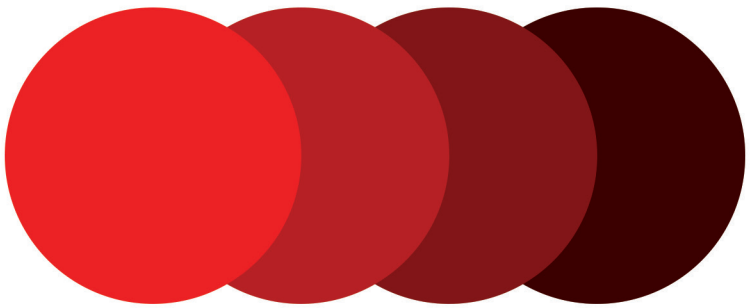


Jim Weiss

Make It Happen



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Jim Weiss

Make It Happen

Interview by **Gevorg Tamamyan**,
the Editor-in-Chief of OncoDaily and World Health Voices

Twenty-five years after building what became Real Chemistry from the ground up, Jim Weiss reflects on mistakes well made, the loss that changed his purpose, the future of healthcare, and the one principle that has guided him through it all: do what you say you are going to do.

Twenty-five years ago, Jim Weiss started a company. There was no grand blueprint for what it would become.

Today, Real Chemistry is a global organization with thousands of people working across multiple locations, at the intersection of healthcare, communications, data, technology and transformation.

How did it happen?

Weiss laughs.

"I don't know."

Then he offers perhaps the best description of his entrepreneurial journey.

"It was a series of mistakes well made."

A Series of Mistakes Well Made

For Jim Weiss, Real Chemistry was never built according to a perfectly designed master plan.

"You kind of just fly and you go and you trip, and then you use those breakdowns to lead to the next breakthrough."

The growth was organic.

A new client opened one door. A new employee brought another capability. Relationships multiplied.

"Every new hire taught us something new. Every new client taught us something new. And we learned from those things."

At the center of it all was something much less complicated than strategy decks or financial models.

Relationships.

Jim had spent years on the client side before becoming an entrepreneur, building a network that followed him into his next chapter. Clients became friends. Colleagues became clients. Employees went elsewhere and eventually returned as partners.

Over time, the network became an ecosystem.

When he looks back, Jim reduces the success of Real Chemistry to three things.

"Really great people, really great clients, and the third important thing is partnering with those clients to create great work that ultimately impacts patients' lives and caregivers' lives."

It sounds simple.

It rarely is.

A Firm I Would Hire

The name **"Real Chemistry"** came much later, but the philosophy was there from the beginning.

Weiss had spent years being the client.

That mattered.

"I used to say I want to have a firm that I would hire."

He knew exactly what he disliked about the traditional client–agency relationship.

"I want them to be an extension of my team. I want to be treated like a colleague, not a vendor."

That distinction shaped the company.

For Jim, communications could never be just a collection of tactics. To become truly valuable, a consultancy had to understand the business behind the communications.

"Our job is to know the client's business better than they know it."

And then stay long enough to matter.

Many Real Chemistry relationships have lasted a decade or even two.

The objective, he says, is to ultimately be on the same mission.

"To make the world a healthier place in some way and help impact patients' lives."

Jim Weiss had already witnessed what that could mean during his years at Genentech.

"We launched the first new cystic fibrosis drug in 30 years. We launched Herceptin for HER2-positive breast cancer, which changed the way we think about how to treat cancer across the board."

Then came immunotherapies, antibody-drug conjugates,

from Jim Weiss LinkedIn

CAR-T therapies, and eventually mRNA vaccines.
Each breakthrough required science.

But science alone was not enough.

"You had to do that in partnership with the client. And so that's Real Chemistry. You have to have real chemistry to do that well."

Then cancer entered Jim's life in a completely different way.

When Cancer Became Personal

His wife became ill.
For months, there was uncertainty.

"We wanted to believe it was something digestive or something that could be treated. I think there was a good year of searcdhing for that diagnosis."

Eventually, they found the answer.

Small bowel cancer.

Stage IV.

"I think it completely shocked my wife. It was less so for me, but it's still a shock when that happens."

Jim knew cancer professionally.

He had spent decades communicating about medicines, patients, science and innovation.

He had also experienced cancer in his family before. His mother had developed lung cancer after decades of smoking.

But this was different.

"I went from somebody who was communicating in the world to experiencing it very real and fundamentally."

He became a caregiver.

The experience eventually contributed to his decision to move from CEO into an active Founder and Chairman role at Real Chemistry.

More importantly, it changed his why.

He had spent his career asking how healthcare companies communicated.

Now he began asking a much more personal question.

"How are we really going to impact how healthcare gets administered, and how do patients and caregivers get the agency back to at least guide and control their own healthcare rather than having that imposed on them?"

That question became part of the motivation behind his podcast, ***Get Real with Jim Weiss.***

And it changed how he saw the entire healthcare system.

Prevent the Event

For Jim Weiss, one of healthcare's deepest problems is that it remains too reactive.

"We're kind of more in reactive mode than we are in proactive mode."

We wait for disease.

We diagnose it.

Then we treat it.

He believes the next transformation must begin earlier.

"We have to shift from a treatment-oriented healthcare system to one of prevention. We have to shift it."

He calls the idea simply:

"Prevent the event."

That requires much more than communication campaigns. It requires molecular medicine, genetics, genomics, better diagnostics and earlier identification of risk.

"We have to use molecular medicine. We have to use early diagnosis. We have to use genetics and genomics to figure out how to treat disease."

And patients can no longer be passive participants. Communication, he argues, must become more open, and the patient voice must sit much closer to the center of decision-making.

Healthcare has already moved in that direction.

But not fast enough.

Follow the Data

If he were starting again today, there is one thing Jim Weiss would do differently.

"I would not overreact."

He repeats it.

"I would not overreact."

Entrepreneurship trains people to move quickly.

Sometimes too quickly.

"I was so active and reactive rather than contemplative."

Experience has taught him something else.

"Take a beat."

A competitor announces a new AI platform.

The natural instinct is to immediately respond.

To prove that you have one too.

To put something into the market before someone assumes you are behind.

Jim believes that instinct can be dangerous.

Instead, build something real.

Understand what it means.

Make sure it works.

Then talk about it.

"Real in Real Chemistry, or Get Real with Jim Weiss, has real resonance and meaning. If it's not authentically real and sustainable, then it's just smoke and mirrors."

His favorite expression captures it even better.

"Vision without execution is hallucination."

The precise origin of the quote may be debated.
The message is not.

"You've got to really do what you say."

Mistakes will happen.

People will disappoint you.

Strategies will fail.

Clients will criticize you.

For Jim, the question is what happens next.

"When the client gives us feedback, we listen, we take it, and we improve."

He smiles.

"We make mistakes really well."

Just Start It

What advice would he give to somebody who wants to build a company today?

There is no complicated answer.

"Just start it."

Then again:

"Just, just, just start it."

Weiss remembers looking for reasons not to continue during the early years.

Building a company is hard.

Everyone has an opinion about what you should do.
His response?

"They can have a voice. They don't get a vote."

Listen.

Learn.

But ultimately, trust yourself.

"Go ahead. Trust your instincts and do it. But really do it.

Don't talk about it. Don't think about it. Really do it."

He has condensed that philosophy into the mantra he wants to carry into whatever comes next.

"Make it happen."
And then the rule behind it:

"Do what you say you're going to do."

If you do that, Jim believes, you have already solved most of the problem.

Get Back on the Horse

One of the most important lessons of Weiss's life came long before Genentech, Real Chemistry or healthcare.

It came at a horse show.

As a boy, Jim was involved in equestrian show jumping. He worked at a stable and eventually helped train horses.

At one competition, he lost.

And he was not happy about it.

"I was being a sore loser."

His "horse-riding mom," as he calls the woman who became a surrogate mother to him at the stable, came over. Her message was direct.

"Buck up. Get on that horse. Go out in the ring. Stop crying."

Lose.

Learn.

Get back on the horse.

For some reason, the moment stayed with him.

"Things can go wrong. You don't have to be whiny and emotional about it. You can actually use it and then proceed."

Decades later, life tested that philosophy in a way no horse show ever could.

His wife underwent roughly two and a half years of treatment after her diagnosis.

Then she died.

"She died in my arms. I looked in her eyes and saw that."

Afterward, some people felt Jim returned to the world too quickly.

He saw it differently.

"What do you want me to do? Shut the door behind me and turn off the lights?"

He had lived through the diagnosis.

The treatments.

The caregiving.

The loss.

Now he wanted to live.

"I've been through this. I want to be in the world again."

His wife had her own description of cancer.

She called it:

"A gift wrapped in barbed wire."

The barbed wire was obvious.

But the gift, as she saw it, was that cancer woke her up to the world around her.

It pushed her to give back, including through her work with Patrick Dempsey's organization.

For Jim Weiss, her death made one truth impossible to ignore.

"We don't have a lot of time. We just don't. We don't have as much time as we think."

So:

"You've got to get on with it."

Science Needs Connection

Jim Weiss believes we are living through one of the most powerful scientific periods in human history.

But scientific progress still moves too slowly.

Part of the problem, he says, is fragmentation.

"There's too many silos at work at their own purpose rather than collaboration."

Cancer makes that challenge particularly visible.

There is no single cancer.

There are hundreds of diseases, increasingly defined by their molecular biology rather than simply the organ where they began.

That complexity is precisely why collaboration matters.
"We've never had more power."

AI may become one of the tools that finally helps connect some of those silos—allowing knowledge to move faster and collaboration to happen more broadly.

For Jim Weiss, the lesson is the same one that built Real Chemistry.

"Collaboration, really working together, is what makes things go faster and better."

The Connected Tissue of Oncology

Toward the end of our conversation, I turned the question toward ourselves.

What should OncoDaily do better?

Jim Weiss answered with another lesson from his mother.

"The moment you think you've arrived, it's time to leave."

Never become too satisfied with what has already been built.

Never assume the current model is the final one.

"We know we have to keep getting better."

His advice went beyond media.

There are hundreds of oncology meetings, scientific societies, researchers, clinicians, companies, patient organizations, funders and publications.

But who is connecting them?

"How are they connecting all the intelligence?"

That, he believes, is the opportunity.

"OncoDaily should be existing to create the connective tissue of the oncology community—from patients to researchers to funders to all the different elements."

Because communication, in Jim Weiss's view, is not something that follows leadership.

It is leadership.

"Communications is leadership. Leadership is communications."

If people cannot understand what you are doing, they cannot connect to it.
And if they cannot connect, collaboration becomes impossible.

The challenge for a platform such as OncoDaily, he says, is therefore not only to publish more information.

It is to connect the information—and the people behind it.

Don't Hire Yourself

After twenty-five years of building teams, Jim Weiss says one of the hardest parts of leadership remains choosing the right people.

The biggest temptation?

Hiring people who look and think like you.

"It's really the hardest thing to do—not hire a bunch of people that are just like you."

People naturally enjoy being surrounded by those who reinforce their worldview.

But that can become dangerous.

"You've got to have a diversity of thought and perspective."

The best people around the table are sometimes the ones who make the conversation less comfortable.

"If you don't surround yourself with people who challenge you, then you're going to miss out."

Jim Weiss found some of that value working with private equity partners who did not necessarily know his industry as deeply as he did.

What they could do was ask difficult questions.

"They asked good, hard questions."

That forced him to think.

And sometimes that is exactly what a leader needs.

"Having people around you that are not yes people is really important."

His description of the ideal colleague is memorable.

"Sometimes somebody that tells you you're not wearing any clothes is the best person to have on your team."

Seek Out Mentors. Be a Mentor.

Jim Weiss can name many people who shaped him.
His mother.

His surrogate mother from the equestrian world.

The strong women who became bosses, clients and colleagues throughout his early career.

The leaders at Genentech who taught him to follow the data.

Mentorship, he believes, should never be treated as something that ends once a person becomes successful.

"Seek out mentors and be a mentor."

Then pay it forward.

"Be a coach, be a mentor, create a culture of that."

Perhaps the best compliment Jim receives today is when someone tells him he helped them see something in themselves that they had not seen before.

That, ultimately, may be one of the purest definitions of leadership.

Helping another person recognize what they are capable of becoming.

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Twenty-five years after he started, Jim Weiss has built much more than a company.

But when you strip away the thousands of employees, the clients, the technologies, the acquisitions and the growth, his philosophy remains remarkably simple.

Make mistakes.

Learn from them.

Take criticism.

Follow the data.

Surround yourself with people who challenge you.

Don't overreact.

Take a beat.

Get back on the horse.

And remember that time is shorter than we think.

Then:

"Make it happen."

Because in business, in healthcare and perhaps in life, doing what you say you are going to do may still be the most powerful strategy of all.

Guess Who is OncoDaily ?

OncoDaily vs other oncological platforms according to daily traffic from Ahrefs

"Life is not easy for any of us. But what of that? We must have perseverance and above all confidence in ourselves. We must believe that we are gifted for something and that this thing must be attained."
- Marie Curie

By Women, for Women

The Untold Stories at the Roots of Oncology

By Mariam Harutyunyan
Deputy Managing Editor, OncoDaily
Associate Editor and Writer, OncoDaily Magazine

Historically, women were excluded from or denied the opportunity to practice science. Yet, even within these constraints, some of the greatest achievements in science owe much to women. They made discoveries that transformed medicine and shaped the way we understand and treat cancer today.

Here, we reflect on the historic impact women have had on oncology and the legacy they leave to inspire us today.

Who Wrote the Breast Cancer Bible?

Did she really suggest a group of women activists march topless in front of the White House?

Yes, and she didn't expect to get taken seriously.

Back in the 90s, when treatment decisions were made

only by doctors and patients had no choice but to follow, Susan Love had the right answer at the right time. Women were ready to make their voices heard in a field where men made all the calls, make informed choices about their bodies, and get a seat at the decision table. She was one of the few physicians of her time who not only treated patients but also advocated for them. So she led a transforming movement that paved the path for breast cancer advocacy.

For decades, the standard treatment for breast cancer was an unquestioned path. Surgeons routinely removed a woman's entire breast, muscle, and lymph nodes. Women had no voice in the medical decision regarding their health and body. This aggressive surgery was simply what doctors had been trained to do, not necessarily what they needed to.

Susan Love pictured with Dr. Susan Love's Breast Book. (Photo Credit: National Library of Medicine / NIH / Public Domain)

At that time, few women entered surgery, and when they did, they were not trusted to perform major surgeries, and most of them usually went into breast surgery. Susan Love was one of them. She argued that performing breast-preserving lumpectomy or wide excision followed by radiotherapy, to everyone's surprise, was just as effective as mastectomy.

"It was a time when we had science, and we had the National Surgical Adjuvant Breast and Bowel Project (NSABP) doing research and randomized trials, and we could start to change how we treated breast cancer based on data, which was really something new and novel," she said in a 2021 Cancer Letter interview.

Susan was one of the few surgeons in her time willing to enroll patients in those trials.

She published Dr. Susan Love's Breast Book in **1990**, which became known as the **"bible"** for breast cancer patients for its raw, open breakdown of treatments and option choices.

During her book tour in Salt Lake City, more than 600 people gathered to listen to her. What happened next was bigger than a successful book tour. In her speech, Love proposed something so outrageous that she expected it to die in the room:

"We should march topless on the White House."

The women were ready. The point was not nudity. It was the disruption.

Patients were tired of being spoken for.

Love was the voice of the crowd; Fran Visco, a lawyer and breast cancer survivor, knew how to organize it. In 1991, Love and other activists founded the **National Breast Cancer Coalition.** Visco became its president and a powerful figure in Washington. The coalition demanded more than awareness: it wanted women to influence research priorities, public policy and access to care.

It launched the **"$300 Million More" campaign,** demanding a major increase in federal breast cancer research funding. Despite the amount being bizarre, in 1992, Congress granted $210 million to create the peer-reviewed Department of Defense Breast Cancer Research Program, and by 1993, the campaign had the federal increase they wanted.

In the same year, Love and Visco stood at President Bill Clinton's White House and delivered 2.6 million signatures demanding a national plan against breast cancer.

But winning money was not enough if women had no say in how it was spent. Love and epidemiologist Kay Dickersin developed Project LEAD (Leadership,

American artist and breast cancer activist Matuschka called her post-mastectomy self-portrait Beauty Out of Damage an image that exposed her scar to challenge the silence surrounding breast cancer and conventional ideas of female beauty. She also turned her self-portraits into protest posters, wearing Vote for Yourself like a sandwich board; in spirit, these images were the opposite of the pinkwashing that came later: not softening or selling the disease, but forcing people to see what it did to the body.

Education and Advocacy Development). Its first course was held in 1995. It did not train surgeons; it trained advocates in cancer biology, epidemiology and clinical-trial design, preparing them to question researchers and participate in the rooms where scientific decisions were made.

By then, the **pink ribbon** was becoming the public face of breast cancer. Many organizations of that time used it for advertising. It was supposed to make the disease visible and spread awareness. But awareness could not replace difficult conversations about cancer. In 2002, Breast Cancer Action gave the commercial version of this problem a name: **pinkwashing.** The pink ribbon was there to put pink glasses on watchers' eyes, concealing the disease's brutal reality or profiting without making meaningful change.

Love eventually left active surgery to concentrate on the causes and prevention of breast cancer. She served on the National Cancer Advisory Board and later launched the **Army of Women,** connecting hundreds of thousands of volunteers with researchers who needed study participants.

Her greatest intervention, however, may have been moving women from the waiting room to the decision table, and teaching medicine that **informed patients were not an obstacle to progress, but its main driving force.**

One woman and six men

Every oncologist knows ASCO. Every year, the oncology community gathers, treatment standards are debated and new evidence is presented. Yet fewer know the only woman among those who built it.

In 1964, **Jane Cooke Wright** joined six other physicians in founding the **American Society of Clinical Oncology.** She was **the only woman** and **the only black one** in the group. At the time, medical oncology was still struggling to establish itself as a distinct specialty. The founders wanted a professional home focused on the clinical care of people with cancer, a place where physicians could exchange knowledge, develop standards and move promising therapies into practice. Wright became **ASCO's first**

Secretary-Treasurer and helped guide the young society through its formative years.

She had earned that seat through work that was already reshaping cancer treatment. Jane Cooke Wright fought for chemotherapy, brought it to practice, and created an oncology community that integrates multidisciplinary care we know today.

In the 1950s, chemotherapy was still an outsider: dangerous, inconsistent and regarded by many physicians with suspicion. Wright saw something different: a treatment that might reach those patients that surgery and radiation could no longer help.

In 1949, she started working as a staff physician at New York Public Schools and later as a visiting physician at **Harlem Hospital**. Long before **"personalized medicine"** entered oncology's vocabulary, Wright was already asking whether an individual tumour could help identify its own treatment.

She and her colleagues cultured tumour samples taken from patients, exposed the cells to anticancer agents and compared each laboratory response with the patient's clinical response. During her time in Harlem, Jane and her father, **Dr Louis Wright,** director of the Cancer Research Foundation of Harlem Hospital, began testing folic acid antagonists on 93 patients with different blood tumors and solid tumors.

Seven folic acid antagonists were administered, using different combinations and doses. She was one of the few researchers who tested chemotherapy drugs in a specific order, at a time when very few guidelines for chemotherapy existed. Among the tested agents was **methotrexate.**

Results published in a 1951 paper were the first evidence of methotrexate's efficacy against solid tumors.

To this day, it is used for treating several cancers.

ASCO was not Wright's first leadership role, and her influence continued beyond it. After her father died in 1952, she succeeded him as director of the Harlem Hospital Cancer Research Foundation. In 1964, President Lyndon B. Johnson named Dr. Wright to the President's Commission on Heart Disease, Cancer, and Stroke, chaired by Dr. Michael E. DeBakey. In 1971, she became the first female president of the New York Cancer Society.

Jane Wright was no ordinary scientist. She never confined herself to the narrow image of a scientist. She painted landscapes, loved fashion and was known for her impeccable style. That same independence shaped her career.

Wright's distinction was not simply that she believed in chemotherapy. She gave the field a method: study the tumour, follow the patient, refine the treatment and build an institution capable of carrying the work forward.

The Pap Smear That Could Have Been the Stern Test

In the 1950s, cervical cancer was the leading cause of cancer-related deaths among American women. It is hard to imagine that these days, when we know cervical cancer is preventable and diagnosable as part of a routine check-up for the majority of women.

When the Pap smear entered medical practice, it gave doctors a new way to see abnormal cells before cervical cancer became invasive. But seeing unusual cells was not the same as understanding them. Some

women consequently went through radical treatments, including hysterectomy or radiation, for changes that may never have become cancer. Doctors could not always tell which abnormalities were early warnings and which might disappear without causing harm.

Elizabeth Stern helped give meaning to what appeared under the microscope.

A Canadian-born pathologist and epidemiologist, Stern spent years following women and comparing their Pap test results over time. She showed that cervical cancer did not appear overnight. Cells changed gradually, passing through recognizable stages from normal tissue to **dysplasia**, an abnormal but non-invasive state, and eventually, in some cases, to invasive cancer. Stern also demonstrated an important complexity: dysplasia could progress, remain stable or return to normal. **It was a warning sign, not a cancer diagnosis.**

In 1974, she and her colleagues published a detailed 100-point cytological scale describing the stages of cervical carcinogenesis and the cellular changes associated with them. This helped **standardise the interpretation of cervical samples** that had lacked before.

George Papanicolaou developed the test that bears his name, but Stern helped turn it into a more precise instrument for diagnosis and prevention.

Later, working with scientists at NASA's Jet Propulsion Laboratory, she explored how Pap tests could be analysed digitally and automatically. She also developed a liquid-based method that removed debris and arranged cervical cells more clearly for examination: work that paved the way for modern liquid-based Pap testing.

The Pill

In the 50s, the first oral contraceptives **(Enovid)** were produced, which was an important discovery that gave women direct control over fertility and an opportunity for family planning. But back then, the estrogen doses in the pill were 10 times higher compared to today's low-dose oral contraceptives and caused too many side effects.

In a seven-year observational study, Stern and her colleagues found that women on the Pill had a 6-fold increased risk for cervical cancer compared to nonusers. Published in Science in 1977, these findings supported the movement toward safer, lower doses of birth control pills.

Stern understood that a cervical cancer screening test could save lives, yes, but only if women could reach it. She found that cervical cancer rates were highest and Pap testing rates lowest in poorer Los Angeles communities and moved beyond the laboratory. She designed community screening services that offered free testing, transportation, childcare, flexible hours, follow-up calls and bilingual staff.

For Stern, women were not simply cells on a slide. They were people whose health was shaped by income, language, family responsibilities and whether medicine was prepared to listen.

While we still have a lot to learn about the history of women in oncology, powerful women are making history in our times and we are proud to recognize their contributions to oncology in our **100 Influential Women** in Oncology series which you can find in OncoDaily.

Know a colleague whose work deserves recognition? Scan the QR code to nominate them for the OncoDaily 100.

OncoDaily

100 INFLUENTIAL PEOPLE IN ONCOLOGY 2026

Nominations are open


3.1 million
minutes watched in
July on OncoDaily TV