Over the past year, I have found myself returning to one question with increasing insistence: when a patient walks through the door of an oncology clinic, who, exactly, has walked in?

The obvious answer is a person with cancer. We have become extraordinarily sophisticated at describing the cancer they bring with them. We know its anatomical location and histology, increasingly its genomic architecture, its molecular dependencies and its relationship with its microenvironment. We know how to stage it, sequence it, image it and interrogate it. Precision oncology has given us an unprecedented ability to look deeply into the disease.

And yet, somewhere in our increasingly precise description of the tumour, I wonder whether our definition of the person has become strangely imprecise.

This was the question running through two talks I gave recently, first in Bucharest, under the title *Mind the Gap – Mind the Body*, and subsequently at Cleveland Clinic Abu Dhabi, where I called for *Practicing a New Kind of Intelligence in Oncology*. The second talk was not so much a different argument as the next chapter of the first. Bucharest asked us to notice the gap. Cleveland asked what we might do once we saw it.

Both began from a conviction that has become central to how I understand medicine: ***somewhere between a blood test and a scan, there is a whole person.***

The Gap in Personalised Medicine

Cancer has moved through a succession of explanatory models. We have understood it as an anatomical disease: find it, cut it out, irradiate it, shrink it. We have understood it as a genetic disease and searched for its Achilles heel in mutations and molecular dependencies. We have understood the influence of environment, exposures and behaviour. None of these stories is wrong. Each has transformed oncology.

The problem arises when a part of the truth is mistaken for the whole truth.

The traditional model remains predominantly symptom- and disease-focused. Integrative care proposes something different: not an abandonment of conventional treatment, but a **both/and approach** that seeks to optimize health, quality of life and clinical outcomes while returning agency to the person before, during and after treatment.

This distinction matters because cancer does not occur in an isolated organ. As one of my Cleveland slides simply said, cancer touches everything.

The patient who arrives in front of us has a tumour, but they also have a life. And that life has had a biology of its own.

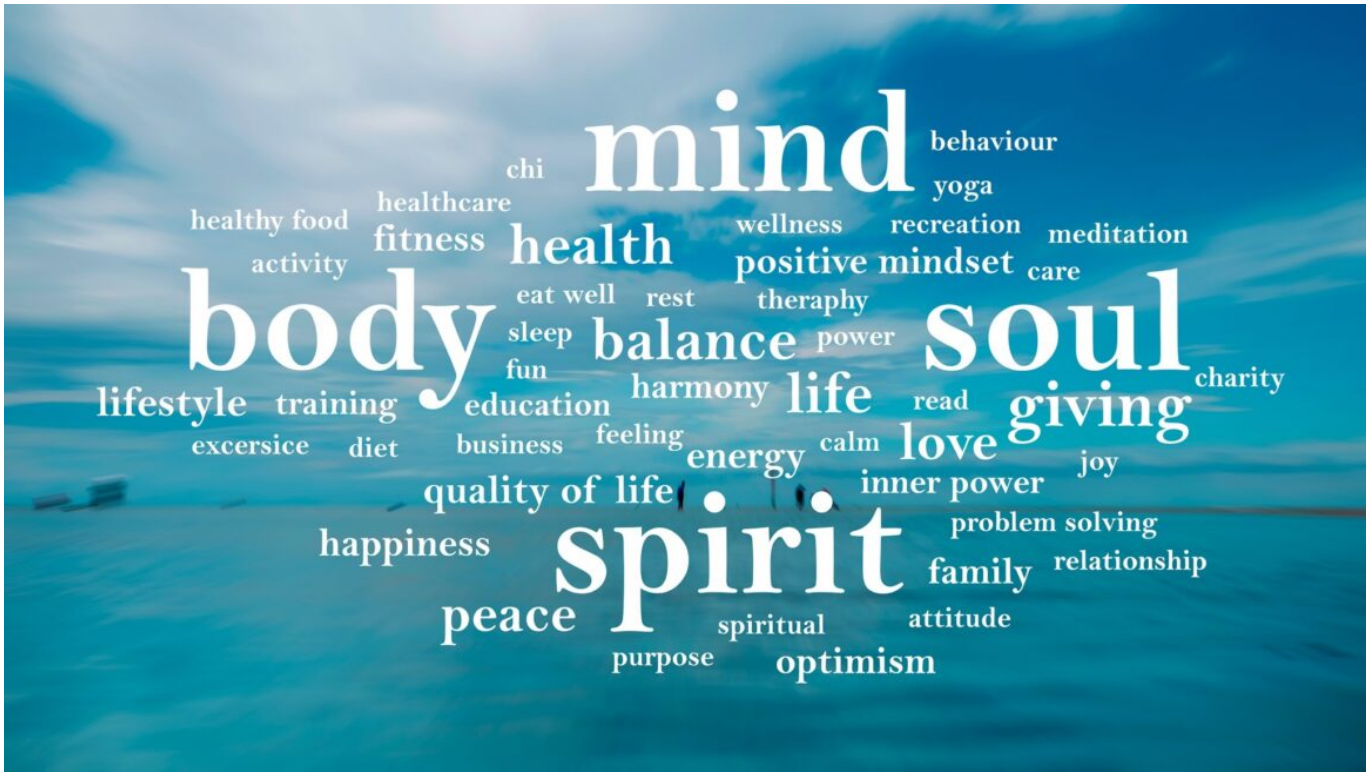
This leads me to what I believe are two of the most overlooked pieces of clinical information in an oncology consultation:

Every patient walks into our office with their story and their nervous system. Both live in the body.

The story shaped the nervous system. The nervous system has participated in shaping the Biology in which the disease now exists. And then the diagnosis itself becomes a new and powerful event in that system.

This is where the conversation about cancer needs to become larger without becoming less

scientific.



What is a Diagnosis?

A diagnosis of cancer—or indeed of any serious disease—is not simply the transmission of medical information. For many people it is an event of enormous emotional and physiological consequence. In the framework I presented, trauma is not limited to the conventional image of a catastrophic event; it can be understood as a biochemical, physiological, behavioural and emotional imprint left by an event or series of events on the nervous system, physiology and emotional state. Trauma can also become a barrier to seeking, receiving and responding to healthcare.

And the story did not necessarily begin with cancer.

The Bucharest presentation deliberately moved backwards through a person's life: adverse childhood experiences and what lies beyond conventional ACE definitions; instability and lack of safety; parental loss or abandonment; family illness; addiction; verbal, physical or sexual abuse; bullying; not feeling seen, loved or accepted; serious accidents; community violence; medical trauma; natural disasters and war.

These are not merely biographical footnotes. Large epidemiological literatures associate cumulative adversity with later health-harming behaviours and increased burdens of physical and mental ill health.

I am not suggesting that trauma "causes cancer." Such reductionism would simply replace one incomplete story with another. I am suggesting that the history of a human organism matters.

A patient does not leave their biography in the waiting room.

Their story enters the clinic in their body.

From Story to Physiology

The next part of the Bucharest talk deliberately travelled from biography towards biology: from stress and trauma to neurobiological substrates of chronic disease; from nervous-system state to inflammation; from unresolved inflammatory processes to the growing scientific interest in the relationship between neural signalling and cancer.

Cancer neuroscience is now a serious field of scientific inquiry. Tumours can be innervated, autonomic nervous-system signalling can interact with tumour biology, and neural inputs have been studied in relation to processes including angiogenesis and immunosuppression within the tumour microenvironment.

The important point is not to leap from those observations to the unsupported conclusion that regulating one's nervous system will control a tumour. It is to recognise that the conceptual wall we constructed between "mind" and "body" was never biologically convincing in the first place.

The body does not recognise the disciplinary boundaries of medicine.

This is why I deliberately write ***MINDBODY as one word***.

The Bucharest talk also examined emerging clinical evidence linking emotional distress with cancer outcomes and studies in which multidimensional lifestyle interventions have been evaluated alongside conventional cancer treatment. These data require careful interpretation; association is not causation, and complex interventions do not allow us to attribute an outcome to a single component. But collectively they justify something important and much less controversial: taking the internal state and lived experience of our patients seriously is not an indulgence outside "real oncology."

It belongs within our scientific curiosity.

The Diagnosis Acquires a Neurotag

Cleveland took this argument somewhere more practical.

Neurosomatic intelligence, as I use the term, is the ability to recognise how sensory and cognitive inputs affect the nervous system and, where appropriate, intentionally change those inputs to facilitate greater regulation, adaptive behaviour and healing. Its starting point is simple: the nervous system is fundamentally organised around safety and survival.

It is continuously receiving inputs—from vision, hearing, touch, smell, taste, movement, internal sensations, thoughts and information—processing them, making decisions and producing outputs.

Experiences become associated with patterns of neural activation. In the language of the framework I teach, these can be thought of as **neurotags**. Pain has a neurotag. Fear has one. Memories, movements and emotions are embedded within patterns of activation and association. When sufficient sensory, emotional or contextual inputs accumulate, a familiar pattern can fire and produce an output; over time, some of these loops may become maladaptive.

And a diagnosis can acquire a neurotag quality too.

Think about what that means clinically.

A patient may no longer be responding only to the cancer that exists today. Their body may also be responding to the room in which they first heard the diagnosis, the smell associated with chemotherapy, the scan that previously brought bad news, the phrase a doctor once used, the sight

of a hospital corridor, the week before a surveillance appointment.

The body learns.

And sometimes loops do not close.



And then, there was Word

There is another input that medicine uses continuously and sometimes rather casually: language.

The Greek *onkos*, from which oncology derives, means burden or weight. I find that origin striking because words themselves can carry extraordinary weight.

“Cancer” is not received by a patient as a neutral biomedical noun. Neither are “progression,” “failure,” “incurable,” “palliative” or “nothing more we can do.” Medical language carries biological information, certainly, but also emotional, autobiographical and cultural meaning. I have come to

think of words as ***bio-symbols***: symbols interpreted not only intellectually but within the embodied context of the person hearing them.

This is not an invitation to euphemise reality. Truth matters enormously in oncology.

But truth does not require carelessness.

How we frame diagnosis, prognosis and treatment can amplify threat or create clarity, agency and hope. The content of a sentence may be medically identical while its physiological and relational impact is entirely different.

Our words are therefore not merely descriptions of the clinical encounter.

They are part of the clinical encounter.

The One Least Uncertain

This brings us to authority.

When someone is diagnosed with cancer, certainty suddenly collapses. Their imagined future, assumptions about their body and often their sense of control are destabilised. Into that uncertainty walks the oncologist.

We may become, as I described it in Cleveland, ***"the one least uncertain."***

Not all-knowing. Not infallible. Simply less uncertain than the frightened person opposite us.

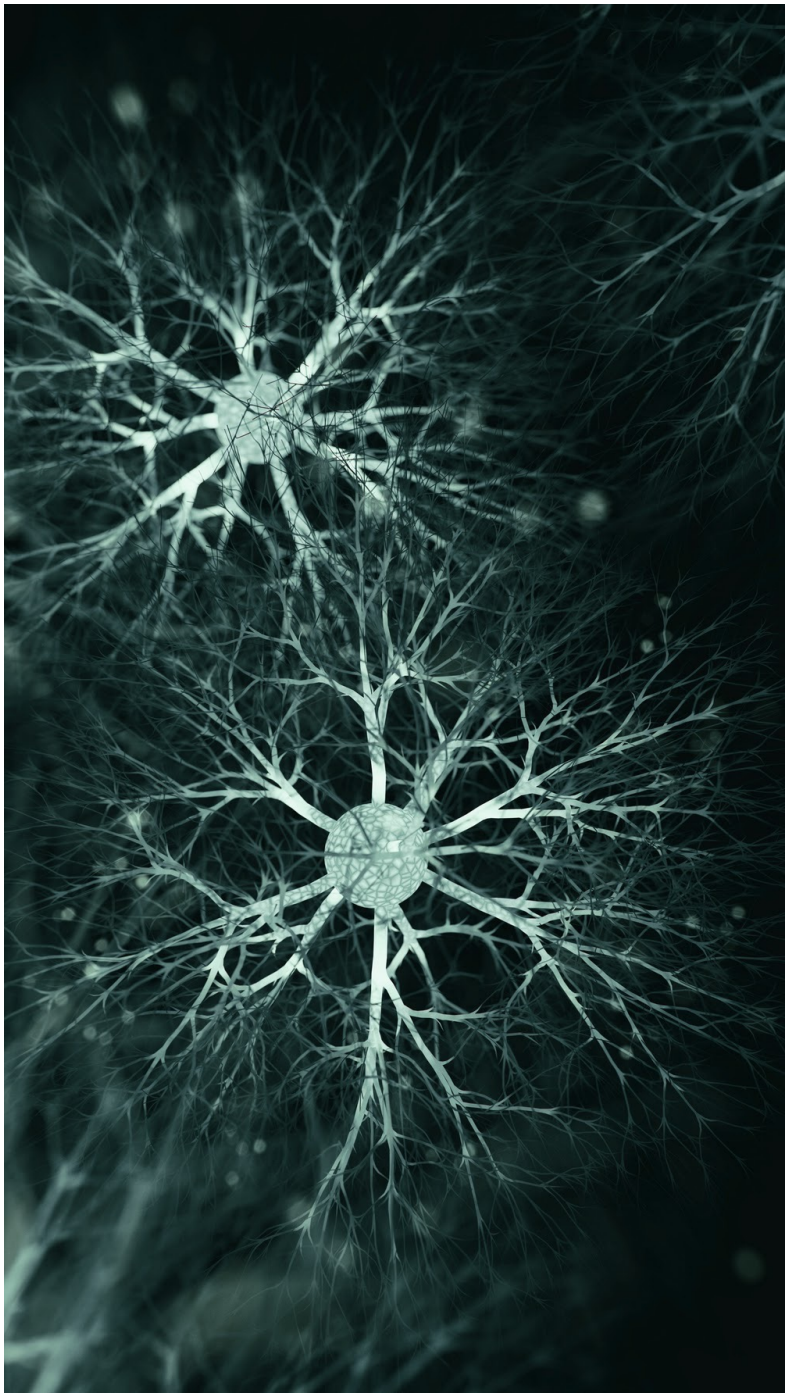
That position carries enormous relational power.

Patients bring their previous relationships with authority into medicine. Some hand their agency to us readily. Others distrust authority. Some are highly sensitive to facial expression, posture or tone. The task is therefore not simply to communicate information accurately, but to create sufficient relational safety for the person to remain present and retain agency while receiving it.

The model I presented uses four deceptively simple words: ***presence, attunement, resonance and trust***. Adaptive presence asks the clinician to notice the person in front of them and modulate posture, tone and delivery accordingly.

And it is at precisely this point that the argument has to turn around.

Because the patient is not the only nervous system in the room.



Two Nervous Systems, One Room

This may be the slide in the Cleveland presentation that matters most to me now.

On one side:

I didn't sleep last night.

What is the scan going to show?

Will I get side effects?

What will I tell my kids?

Will I offend him if I ask for a second opinion?

On the other:

Traffic was horrible.

The waiting room is overflowing.

The clinic is running behind.

Fifty unanswered emails.

Five deadlines.

That colleague…

And then these two people meet.

Two nervous systems. One room.

We speak frequently about the emotional state of patients. We speak less about the state of the clinician who is about to encounter them.

Yet the clinician's nervous system is not left outside the consulting-room door while their expertise walks in.

Who am I when I enter that room?

Am I present or rushing? Curious or already deciding? Regulated or activated? Am I capable of tolerating the patient's fear without needing to make it disappear? Can I sit with uncertainty? Can I hear anger without immediately becoming defensive? Can I allow silence, or does silence make *me* uncomfortable?

One of my Cleveland slides asks simply: ***Who are you when you are regulated?***

Engaged. Curious. Energetic. Emotionally stable. Mentally clear. Resilient. Centred. Grounded.

These are not merely desirable wellness outcomes for doctors.

They are clinical capacities.

And this is why I increasingly believe that doing our own inner work is part of our professional responsibility.

The patient should not have to manage our discomfort.

They should not have to reassure us because their suffering has overwhelmed us. They should not have to soften their questions because we become defensive. They should not have to carry our urgency, exhaustion or fear in addition to their own.

It is our duty to hold the patient. It is not the patient's duty to hold us.

That does not demand perfection from clinicians. It demands awareness.

Doctors are human. We become tired. We are frightened. We grieve. We become frustrated. We carry patients home in our minds. Sometimes we make mistakes. Sometimes a patient dies and we

open another door ten minutes later.

The point of regulation is not to become less human.

It is to become human enough to know what belongs to us before we unconsciously ask somebody else to carry it.

The body is not a thing. The body is a process.

Once nervous-system state becomes visible, we can begin to work with it.

The Cleveland talk moved through fight, flight and freeze states and practical ways of responding to them: orientation to the room; grounding through the feet; pushing against a wall; movement and shaking; releasing the jaw; vocal or prolonged exhalation; hand-to-heart and hand-to-belly; simple vagal practices; bilateral movement; tapping; opening the chest; naming one's full name and the date; and the deceptively powerful reminder, **"That was then. This is now."**

These are not intended as substitutes for psychological or psychiatric treatment, nor do I propose turning oncology consultations into hour-long somatic therapy sessions.

The point is far more practical.

A clinician can learn to recognise when the human being opposite them is mobilised, trying to escape, or shutting down. And sometimes a two-to-five-minute intervention can help that person become sufficiently present to hear the information we are about to give them.

The same is true for us.

Before opening the next door, feel your feet.

Orient to the room.

Notice your breathing.

Exhale.

Ask yourself what state you are carrying into the encounter.

That may take thirty seconds.

But thirty seconds of awareness can change what happens next.

This is the premise behind the **neurosomatic-centred micropractices for the clinic** with which I concluded the Cleveland talk. The slide was headed by a sentence that captures the philosophy better than almost anything else I could write:

The body is not a thing. The body is a process.

If the body is a process, then regulation is a process. Healing is a process. The doctor–patient relationship is a process.

And the process changes both participants.

For patients, a nervous-system-informed encounter may increase the sense of being seen, heard and

understood and may reduce anxiety and treatment-related distress. For oncologists, the proposed benefits include emotional resilience, communication, presence, meaning and potentially protection against compassion fatigue and burnout. At a systems level, the aspiration extends to staff retention, absenteeism and team culture.

In other words, this is not something else we do **to** patients.

It is something we learn to practise with them.

Healing as Rewiring

Both talks eventually arrived at the possibility of change.

In Bucharest, I described healing as a movement from a biology organised around trauma and threat towards one increasingly capable of experiencing safety. The slide deliberately used provocative language: *diagnosis is an assignment written by your body*. The diagnosis may be shared by thousands of people, but the story in which it arose is unique. That, for me, is where holistic care enters personalised medicine—not by replacing oncology, but by bringing the whole person back into it.

The next slide called this ***"when healing becomes a lifestyle—a complete rewiring."*** It described the physiological systems potentially touched by sustained changes in behaviour, stress regulation and lifestyle—from cortisol and inflammation to autonomic balance, cardiovascular function and brain integration.

Cleveland developed the same idea differently: rewiring produces new physiology, and old symptoms and patterns may no longer belong to the new system.

Again, this needs to be said carefully in oncology. We must never burden patients with the idea that they created their cancer through insufficient regulation, nor promise that nervous-system work will cure it.

But neither should fear of overstatement prevent us from asking how an organism changes when its inputs change.

That is a scientific question.

And an intensely human one.

What would it take?

The penultimate questions in both talks were not philosophical. They were practical.

If this matters, how do we bring it into healthcare?

The Bucharest talk proposed trauma-informed clinician competency and medical procedures, organisational readiness, cross-sector collaboration and coordinated referral, alongside stronger research and advocacy for root-cause and body-intelligence-led interventions.

Cleveland evolved this into nervous-system-informed clinician competency, NSI-informed medical procedures, staff and organisational readiness, and cross-sector collaboration. But I added one final line:

If the only takeaway from today is your awareness that this matters—that is already more

than enough.

I still believe that.

Not every oncologist has to practise as I do. Not everyone will choose to dedicate their clinical work to integrative oncology and a person-first approach.

Nor should they have to.

But all of us can become more aware of the nervous systems we meet.

All of us can take two minutes.

All of us can ask one different question.

All of us can become more intentional about language.

All of us can notice when a patient is no longer able to receive information.

All of us can learn what happens in our own body when somebody cries, becomes angry, asks a question we cannot answer or receives news neither of us wanted.

All of us can look away from the computer for a moment and really see who has walked through the door.

That is not an additional speciality.

That is doctoring.

Treatment is Not Medicine

And perhaps this is where the two talks have taken me since I gave them.

I have begun to wonder whether one of the most consequential things modern healthcare has done is to quietly make ***treatment*** and ***medicine*** synonymous.

They are not.

Treatment is chemotherapy, surgery, radiotherapy, immunotherapy, a transplant, a drug, an intervention. Treatment is something medicine has become extraordinarily good at delivering.

But medicine is older than treatment.

Medicine existed before hospitals. Before scanners. Before drugs. Before we had names for most diseases.

We have somehow sequestered medicine inside buildings and professions, as though it belongs to hospitals and clinics and is dispensed by people with licences.

Yet medicine also lives within the human organism—in its capacity to regulate, adapt, repair, reorganise and seek equilibrium.

And medicine lives ***between*** human beings.

Sometimes medicine is the drug I prescribe.

Sometimes medicine is the way I tell you that the scan has changed.

Sometimes it is the question I ask before I prescribe anything.

Sometimes it is helping you remain inside your body while I tell you something frightening.

Sometimes it is silence.

Sometimes it is the moment in which you realise that I am not frightened of your fear.

Treatment is something we do. Medicine is also something that happens between us.

That does not diminish the importance of treatment.

It restores the meaning of medicine.

Rachel Naomi Remen's words appeared in both presentations: *"We thought we could cure everything, but we can only cure a small amount of human suffering. It turns out, the rest needs healing."* The talks then offered several ways the literature has described healing: making whole again, transformational change, transcending suffering, regaining balance and peace.

Perhaps the distinction matters particularly in oncology because sometimes we can cure.

Sometimes we cannot.

But there is never a moment at which we cannot practise medicine.

If You Ask Me My Name

There is one final nervous system in this story.

The doctor's.

I ended Cleveland with Richard Berlin, MD's poem ***"If You Ask Me My Name."***

It is a small poem carrying an enormous amount of weight. Berlin moves through the many selves contained within the word *doctor*: healer and priest, arrogance and fear, distance and exhaustion, proximity to death, responsibility for children, the strange shifting roles of mother, father, hero and fool. Then all of those identities collapse back into the simplest possible name: doctor.

I chose it because conversations about clinician regulation can too easily become another demand placed upon doctors: be more present, more empathic, more regulated, more resilient, more available.

That is not what I mean.

We should also acknowledge what a doctor holds.

The responsibility is real.

The weight is real.

The gravitas is real.

To sit opposite another human being and tell them what you believe is happening inside their body is

an extraordinary privilege. To recommend something that may save their life and may also harm them is an extraordinary responsibility. To accompany people through fear, pain, hope, recovery, recurrence and sometimes death changes us too.

We should not trivialise that in our efforts to improve medicine.

We should honour it.

Which is why the question I want to leave with my colleagues is not another clinical question.

It is this:

What does doctoring mean to you?

Not what did it mean when you wrote your medical-school application.

What does it mean ***now****?*

After the training, the night shifts, the exams, the guidelines, the MDTs and tumour boards. After the patients who recovered and the patients whose names you still remember because they didn't. After the times medicine worked exactly as you hoped and the times it did not.

What are we actually doing when somebody walks through our door and entrusts us with their body, their story and, for a period of time, part of their future?

Perhaps we begin by remembering that there are two nervous systems in that room.

The patient's nervous system arrives carrying a story.

The clinician's nervous system arrives carrying one too.

Our responsibility is not to erase either story. It is to become sufficiently aware of our own that, for the time we are together, the patient does not have to carry it.

Then we met.

Human to human.

And somewhere in that meeting there will be science, expertise, evidence, scans, pathology, molecular biology, decisions and treatment.

But there may also be something else.

Connection.

And perhaps that is not the soft part of medicine.

Perhaps ***that is medicine****.*

About the Author

Aleksandra Filipović, MD, PhD, is a medical oncologist, cancer cell biology scientist, drug developer, and educator. She earned her PhD at Imperial College London and now serves as Head of Oncology and Chief Medical Officer within the biotech sector. Dr Filipović practices and teaches

integrative oncology internationally and hosts the OncoDaily TV podcast “*Into the Body, with Dr Aleks*”.