



A Hermeneutic Critique of Modern Oncology: Towards an Afro-Regenerative Approach to Cancer Care

Abstract

Modern oncology has transformed cancer diagnosis and treatment through molecular pathology, precision diagnostics, targeted therapy, immunotherapy and evidence-based protocols. These advances remain indispensable, especially in a world where cancer continues to be a leading cause of mortality and where the burden is rising unequally across regions. However, the same biomedical orientation that makes oncology scientifically powerful can also narrow the meaning of illness to cellular abnormality, tumour response and survival metrics. This study offered a hermeneutic critique of modern oncology by examining the ontological and epistemological assumptions that shape contemporary cancer care. Drawing on philosophical hermeneutics, medical anthropology and African relational ontology, it argued that cancer is not only a biological event but also a disruption of meaning, identity, temporality, family life and communal belonging. In response, the study proposed an Afro-regenerative framework of cancer care. This framework does not reject biomedical oncology or romanticize African communal life. Rather, it re-situated evidence-based treatment within a broader account of the person as embodied, interpretive and relational. Afro-regenerative care therefore understands healing as biological treatment together with the restoration of existential coherence, psychosocial support, relational recognition and meaningful participation in life. The study contributed conceptually to philosophy of medicine, global oncology and intercultural healthcare by expanding the horizon of cancer care beyond disease eradication alone.

Keywords: Modern oncology, African relational ontology, Afro-regenerative care, cancer, healing, psychosocial oncology.

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Introduction

Through advances in molecular biology, imaging, pathology, surgery, radiotherapy, systemic therapy, immunotherapy and precision oncology, cancer has increasingly become a disease that can be classified, staged, targeted and, in some cases, cured or converted into a manageable chronic condition. Contemporary cancer control is also a public health urgency. Global estimates for 2022 reported nearly 20

million new cancer cases and 9.7 million cancer deaths, while current WHO reporting continues to emphasize cancer as a leading cause of death, with large disparities in diagnosis, treatment, palliative care and survival across countries (Bray *et al.*, 2024; World Health Organization, 2026). In sub-Saharan Africa, the burden is especially urgent because late presentation, weak screening systems, limited radiotherapy access, fragile pathology infrastructure and high out-of-pocket costs continue to

shape outcomes (Ngwa *et al.*, 2022). The success of modern oncology depends partly on reduction. Cancer is translated into cellular, genetic, immunological and molecular mechanisms that can be observed, measured and therapeutically targeted. The contemporary language of malignancy is therefore a language of mutation, proliferation, immune evasion, angiogenesis, metastasis, tumour microenvironment and treatment resistance (Hanahan, 2022). Precision oncology further intensifies this orientation by using tumour biomarkers and molecular events to select treatments most likely to benefit particular patients (Repetto *et al.*, 2024). This scientific narrowing is not a weakness in itself. But the very basis of oncology's diagnostic reliability and therapeutic power.

However, a central philosophical question remains: does the biomedical intelligibility of cancer exhaust the human meaning of cancer illness? The answer defended in this study is no. Cancer is never experienced only as cellular pathology. It is also lived as fear, uncertainty, stigma, altered embodiment, disrupted family roles, financial pressure, changed temporality and possible loss of social identity. Recent global oncology literature increasingly acknowledges this human deficit. Psychosocial distress remains widely unmet in cancer care (Bergerot *et al.*, 2024), anxiety and depression require systematic assessment and management in survivorship (Andersen *et al.*, 2023), and palliative care is now recommended as an integrated component of oncology rather than an

end-of-life afterthought (Sanders *et al.*, 2024). The 2025 Lancet Oncology Commission on the human crisis in cancer similarly argues that biomedical progress has not been matched by sufficient attention to meaning, connection and human-centred care (Rodin *et al.*, 2025).

This paper therefore develops a hermeneutic critique of modern oncology and proposes an Afro-regenerative approach to cancer care with particular attention to Igbo conceptual resources associated with igwebuike thought and complementary ontology. African philosophical traditions frequently emphasize relationality as constitutive of personhood where being is understood not as isolated individuality but as fundamentally embedded within networks of relationship and interdependence (Mbiti 1969). In Igbo philosophical discourse, thinkers such as Innocent Asouzu have articulated complementary ontologies in which reality is understood as a network of mutual dependence, while scholars associated with Igwebuike philosophy, including Ikehukwu Anthony Kanu, develop notions of relational existence in which being is intelligible through interconnectedness rather than isolated substance. More so, hermeneutics is employed in this study because illness is not merely an object to be explained; it is also a reality interpreted by patients, families and clinicians within concrete worlds of meaning. African relational ontology is used because many African philosophical traditions understand personhood as constituted through

relation, reciprocity and communal embeddedness.

The paper therefore argues that these relational philosophical resources enable a re-conceptualization of cancer care that extends beyond the limits of biomedical reductionism. It proposes an Afro-regenerative approach to cancer care understood not as a rejection of biomedical oncology, but as a broader interpretive framework in which healing includes biological treatment as well as the restoration of relational integrity, existential meaning and communal belonging. Its distinctiveness lies in treating these dimensions not as adjuncts to treatment but as constitutive dimensions of healing itself. Afro-regeneration, in this sense, means a shift from disease-centered intervention to a more comprehensive understanding of healing as the restoration of disrupted human worlds.

The Reductionist Achievement and Limit of Modern Oncology

Modern oncology became powerful by relocating the explanation of cancer from the whole person to increasingly precise biological levels. The historical movement from gross tumour observation to cellular pathology, histopathology and molecular oncology made cancer clinically actionable. Through this movement, malignant disease became describable in terms of abnormal cell growth, genetic alteration, dysregulated signalling, immune escape and metastatic spread. The scientific value of this approach is clear. It permits classification, comparison, prediction and intervention. Staging systems,

histological grading, molecular testing, tumour boards and randomized trials all depend on translating complex human conditions into categories that can guide treatment.

Surgery, radiotherapy, chemotherapy, endocrine therapy, targeted agents, immune checkpoint inhibitors, cellular therapies and molecularly selected regimens have changed the prognosis of many cancers. The updated hallmarks of cancer demonstrate the richness of molecular oncology by showing that tumours acquire complex biological capacities, including sustained proliferative signalling, resistance to cell death, genome instability, inflammation, phenotypic plasticity, non-mutational epigenetic reprogramming, microbiome interactions and immune modulation (Hanahan, 2022). Recent precision oncology reviews show continuing advances in predictive biomarkers, tumour-agnostic therapies, rational drug design and combination strategies (Repetto *et al.*, 2024). These developments confirm that reductionist methods can generate life-saving knowledge.

Scientific medicine must isolate variables in order to measure them. It must abstract the diseased body from the fullness of the patient's life-world in order to produce stable diagnostic and therapeutic categories. This abstraction is methodologically necessary, but it becomes philosophically inadequate when it is mistaken for the whole reality of illness. It is within this context that Engel's critique of biomedical reductionism becomes significant. Engel (1977) argues that the dominant

biomedical model tends to isolate biological mechanisms from psychological and social dimensions, thereby producing an incomplete account of illness. The central argument of Engel is that the biomedical model leaves no room within its framework for the social, psychological and behavioral dimensions of illness, thereby producing an incomplete account of human health (Engel 1977). His bio-psychosocial model does not reject biological explanation but challenges its exclusivity as the dominant interpretive framework in medicine. Similarly, Kleinman (1988) distinguishes between “disease,” understood as biomedical malfunction, and “illness,” understood as the lived experience of suffering. For him, “disease” refers to the clinician’s account of patho-physiological malfunction, whereas “illness” refers to the patient’s lived experience of symptoms and the disruption of everyday life. This distinction reveals that biomedical success in explaining disease does not automatically account for the existential reality of illness as it is lived by patients.

From this perspective, the patient in modern oncology is primarily encountered as a site of biological intervention. Even in increasingly patient-centered models of care, the dominant logic of treatment remains oriented toward measurable biological outcomes such as tumor regression, progression-free survival, and overall survival rates. While psychosocial support and narrative approaches have been incorporated into oncology practice (Charon 2006; Holland and

Breitbart 2010), they often function as adjuncts rather than as constitutive elements of how disease itself is defined and understood.

Modern oncology is successful precisely because it narrows its field of vision to biological mechanisms, yet this narrowing simultaneously limits the extent to which illness can be understood as a lived, relational and existential phenomenon. The clarity gained through reduction is therefore accompanied by a necessary abstraction from the broader human world in which illness is experienced. This tension is not accidental but intrinsic to the general epistemic architecture of biomedical science. The conditions that make cancer scientifically intelligible also delimit what can be meaningfully expressed within its framework. It is precisely this productive but limiting structure that prepares the ground for a hermeneutic and relational reconsideration of cancer care in subsequent sections.

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The result is a structural paradox. Modern oncology is successful precisely because it narrows its field of vision to biological mechanisms, yet this narrowing simultaneously limits the extent to which illness can be understood as a lived, relational and existential phenomenon. The clarity gained through reduction is therefore

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Hermeneutic and the Lived Meaning of Cancer

A hermeneutic critique begins from the claim that human illness is interpreted before it is clinically managed. Diagnosis, prognosis and treatment are never neutral facts floating outside meaning. They enter a patient's world and reorganize how that person understands the body, the future, relationships and mortality. Gadamer's philosophy of health is useful here because it rejects the idea that health can be exhausted by technical measurement. Health is partly silent because it is the unforced capacity to participate in the world; illness becomes visible when that participation is disturbed (Gadamer, 1996). Cancer therefore changes not only cells but also the patient's way of being-in-the-world.

Medical anthropology strengthens this insight. Good argues that medicine is itself a cultural system of meaning, not merely a neutral mirror of biology (Good, 1994). Clinical terms such as stage, grade, remission, relapse, metastasis and prognosis do not only

describe disease; they structure the patient's imagination of possibility and risk. A phrase such as “stage four” immediately reorganizes time, family conversation, spiritual reflection and practical planning. The language of oncology may therefore comfort, terrify, clarify or alienate depending on how it is communicated and interpreted. Narrative medicine responds to this problem by restoring attention to patients' stories. Charon argues that clinical care requires narrative competence: the ability to recognize, absorb, interpret and be moved by the stories of illness (Charon, 2006). This is especially important in cancer, where the patient must often live through repeated tests, uncertain results, treatment toxicities and ambiguous futures. However, narrative attention alone is not sufficient if the healthcare system remains organized around throughput, specialization and biological metrics. Recent work on the human crisis in cancer argues that many patients experience oncology systems as technically advanced but relationally thin, with emotional, existential and social distress treated as peripheral rather than central to care (Rodin *et al.*, 2025).

Hermeneutics therefore does not deny biomedical knowledge rather, it asks what biomedical knowledge leaves uninterpreted. It reminds oncology that the patient's body is not an object detached from a world. The body is the medium through which one works, prays, eats, loves, cares, worships, participates and hopes. When cancer disrupts the body, it disrupts the world

mediated through the body. A hermeneutic approach consequently shifts the question from “What tumour does this patient have?” to “What human world has this tumour disrupted, and how should care respond?”

African Relational Ontology and the Meaning of Healing

African relational ontology deepens the hermeneutic critique by offering a philosophical account of personhood as fundamentally relational. Although African traditions are diverse and should not be treated as a single uniform worldview, many African philosophical accounts emphasize interdependence, reciprocity and communal participation. Mbiti's well-known formulation that the individual exists within the community expresses one version of this insight (Mbiti, 1969). Ubuntu philosophy similarly presents personhood as realized through relations of mutual recognition and humane participation (Ramose, 1999; Metz, 2011). In this view, the self is not an isolated substance that later enters society. The self is formed, sustained and interpreted through relation.

Igbo relational thought provides a further resource. Kanu's articulation of *igwebuike* presents being as strength-in-togetherness, where existence becomes intelligible through plurality, complementarity and mutual dependence (Kanu, 2015, 2016). Rather than treating beings as self-contained entities, *igwebuike* advances the view that intelligibility emerges through relational participation. The concept therefore functions not merely as a

social principle but as a metaphysical account of being itself. Within this framework, isolation represents an abstraction from the relational conditions that make existence meaningful and coherent. It follows that any attempt to understand a person in complete isolation from others produces an incomplete account of the person's ontological status, since being is always already shared, relational and interdependent.

According to Asouzu (2007), reality is structured through mutual dependence such that no entity possesses complete intelligibility in isolation from the wider network of relations within which it exists. His notion of "complementary reflection" challenges all forms of epistemic absolutism by insisting that knowledge remains partial when detached from the totality of relational contexts that sustain meaning. Complementary reflection therefore functions as a critical methodology for overcoming reductionism because it requires that any assertion about reality be tested against its relational contexts and complementary perspectives. In this regard, knowledge is always partial when it abstracts from the network of interdependence that sustains existence. Within the context of cancer care, this implies that biomedical interpretation of cancer remains incomplete when isolated from the relational and existential dimensions of the patient's experience. Complementary ontology therefore rejects fragmentation as both an epistemic and ontological

Generally, therefore, Ubuntu philosophy, igwebuike thought, and

complementary ontology establish a coherent theoretical framework grounded in relational metaphysics. Across these traditions, existence is understood as fundamentally interconnected, personhood as relationally constituted, and meaning as emergent within networks of mutual dependence. Within the context of cancer care, this implies that the cancer patient is not adequately understood as an isolated biological unit but as a relational being whose condition affects and is affected by multiple layers of social and existential relations. This relational understanding clarifies the difference between cure and healing. Cure refers to the biological control, elimination or stabilization of disease. Healing refers to the restoration of wholeness, dignity, meaning and relational participation. The distinction is not an argument against cure. In fact, cure remains a vital dimension of healing because embodied persons need effective biological treatment. The point is that cure does not exhaust healing. A patient may be clinically disease-free but remain socially stigmatized, emotionally fragmented or existentially displaced. Another patient may not be curable but may still experience healing through pain relief, family presence, reconciliation, spiritual support and the restoration of dignity.

African relational ontology also helps correct the individualism sometimes embedded in biomedical care. Cancer decisions are often framed as choices made by an autonomous patient standing apart from communal life. In many African contexts, however, illness

is interpreted and managed through family systems, religious communities, economic networks and social obligations. Ignoring those networks can weaken adherence, communication, trust and dignity. At the same time, an Afro-regenerative approach must not romanticize community. Communities can also stigmatize, silence, exploit or exclude the sick. A critical relational ontology therefore values community not because every communal practice is good, but because human beings are in fact relationally constituted. Good care must strengthen life-giving relations while resisting relations that deepen suffering.

Towards an Afro-Regenerative Framework of Cancer Care

Afro-regenerative care is proposed here as an interpretive and ontological framework for cancer care. It is not an alternative medicine, a rejection of oncology, or a call to replace evidence-based treatment with cultural symbolism. Rather, it is a framework that re-situates biomedical oncology within a broader understanding of the human person. The term “regenerative” refers to the restoration of disrupted human worlds: the patient's biological functioning where possible, but also identity, agency, meaning, relational belonging and practical participation. The framework has five interrelated commitments. First, it affirms biomedical excellence. Surgery, radiotherapy, systemic therapy, immunotherapy, pathology, genomics, palliative medicine and supportive care are essential. Afro-regenerative care would be ethically unacceptable if it

weakened access to evidence-based diagnosis and treatment. In African settings, this means strengthening cancer registries, early diagnosis, pathology, radiotherapy, drug availability, pain control, financial protection and equitable referral systems, all of which remain major priorities in sub-Saharan Africa (Ngwa *et al.*, 2022; World Health Organization, 2026).

Second, it interprets the patient as an embodied relational person, simultaneously biological, psychological, social, cultural, spiritual and economic. This does not mean that all dimensions are identical. It means that they are co-present in the experience of illness. Treatment planning should therefore ask about family structure, caregiving capacity, cultural concerns, work disruption, stigma, transport, cost, religious needs and fears about death or recurrence. Such questions are not ornamental; they shape whether treatment is understandable, bearable and sustainable.

Third, Afro-regenerative care treats psychosocial and palliative support as constitutive, not peripheral. Current ASCO guidance recommends integration of palliative care into oncology for patients with advanced cancer, while psychosocial oncology literature documents persistent unmet emotional and social needs globally (Sanders *et al.*, 2024; Bergerot *et al.*, 2024). Supportive care also emphasizes symptom control, rehabilitation, survivorship support and whole-person care across the cancer journey (Scotté *et al.*, 2023). These developments are

consistent with an Afro-regenerative view because they recognize that treatment must attend to suffering, not merely tumour biology.

Fourth, the framework gives moral importance to interpretation and communication. Cancer diagnosis should not be delivered as information alone but delivered as a human encounter. Clinicians must explain disease and treatment in language that patients and families can understand, while also listening to how patients interpret the diagnosis within their own moral, religious and cultural worlds. This requires neither surrendering scientific accuracy nor endorsing harmful beliefs. It requires dialogical care: correction where necessary, empathy always, and attention to the patient's horizon of meaning.

Fifth, Afro-regenerative care defines therapeutic success more broadly. In addition to tumour control and survival, success includes reduced suffering, preserved dignity, restored agency, family inclusion, spiritual support where desired, social reintegration and survivorship meaning. These outcomes may require multidisciplinary collaboration involving oncologists, nurses, psycho-oncologists, social workers, palliative care specialists, chaplains, community health workers, patient navigators and family caregivers. In low-resource settings, the model also requires practical adaptation rather than expensive imitation of high-income oncology systems. Community-based navigation, culturally competent counselling, survivorship groups, home-based palliative support and faith-

community partnerships may become important, provided they are linked to evidence-based medical care.

Reframing the Subject of Oncology

The major contribution of Afro-regenerative care is not the addition of culture to oncology but the reframing of the subject of oncology. The subject of care is a person whose biological condition is inseparable from a lived world. This reframing has practical and philosophical consequences. Philosophically, it challenges the assumption that psychological, social and spiritual issues are secondary “add-ons” to a primarily biological disease. While biological pathology remains central, the patient's suffering is not reducible to pathology. Fear, stigma, loss of meaning, dependency, financial distress and relational isolation are not merely emotional reactions around the disease; they are part of how the disease is lived. The human crisis in cancer care therefore emerges when systems measure success by technical performance while leaving these dimensions structurally under-addressed (Rodin *et al.*, 2025).

Practically, this reframing supports integrated pathways. Distress screening should not be a luxury service. It should be part of routine cancer care, especially at diagnosis, treatment transition, recurrence, survivorship and palliative phases (Andersen *et al.*, 2023; Bergerot *et al.*, 2024). Palliative care should not be delayed until active treatment has failed; it should accompany disease-directed care where appropriate (Sanders *et al.*, 2024). Patient navigation should not

only move patients through appointments; it should help them negotiate information, cost, family communication, stigma and continuity. In African contexts, such navigation must be culturally aware and resource-sensitive.

The Afro-regenerative framework also has implications for research because global oncology research often prioritizes molecular innovation, drug development and survival endpoints. These remain essential, but they should be complemented by studies of patient experience, cultural interpretation, family caregiving, financial toxicity, palliative access, spiritual distress, survivorship and community-based support. In African contexts, research should avoid importing Euro-American patient-centred models without examining local kinship systems, religious interpretations, traditional explanatory frameworks, health-system constraints and political economy. The goal is not to exoticize African cancer care but to produce conceptually and practically adequate care for African patients.

Nevertheless, the model has limits because it is conceptual rather than clinical, and therefore requires empirical testing in oncology settings. Second, African relational philosophy is internally diverse, so no single model can represent all African communities. Third, relational care may be difficult in overcrowded, underfunded health systems where clinicians lack time and resources. Fourth, community involvement can be harmful if it reinforces stigma or suppresses patient

voice. These limits show that Afro-regenerative care must be implemented critically, ethically and contextually.

Conclusion

This study has developed a hermeneutic critique of modern oncology in order to clarify both its scientific achievements and its ontological limitations. Modern oncology has transformed cancer care through advances in molecular biology, diagnostic precision and evidence-based therapeutic protocols. These advances have made cancer increasingly manageable as a biological condition through standardized staging, targeted therapies and survival-focused treatment strategies. Its success lies in its methodological reduction of cancer to biological mechanisms, which enables clinical control, classification and intervention with unprecedented effectiveness. This reduction, however, also narrows the interpretive horizon through which illness is understood, privileging biological explanation over the broader existential and relational dimensions of human experience. In cancer care, this is reflected in the dominance of tumour-centered metrics such as response rates and survival curves, which may not fully capture the patient's overall experience of illness and recovery.

Hermeneutic philosophy demonstrates that illness cannot be fully understood as a purely biological event because human beings encounter it within horizons of meaning, embodiment, temporality, and social existence. Medical anthropology reinforces this claim by distinguishing between disease

as biological pathology and illness as lived experience, showing that biomedical categories do not exhaust the reality of suffering. Within oncology, this distinction becomes evident when clinical remission does not necessarily correspond to full restoration of the existential stability of the patient or their sense of identity after cancer treatment. These insights reveal that modern oncology, while scientifically indispensable, remains interpretively incomplete. African relational ontology deepens this critique by offering a conception of personhood grounded in interdependence rather than isolated individuality. Within Ubuntu philosophy, Igbo relational thought, and complementary ontology, human existence is understood as constituted through relations of mutual dependence and communal embeddedness. From this perspective, illness is not only a biological disruption but also a disturbance in relational coherence, affecting identity, belonging, as well as existential orientation.

On this foundation, the study proposes an Afro-regenerative approach to cancer care as an interpretive framework that integrates biomedical effectiveness with a broader understanding of healing. Afro-regenerative care does not reject modern oncology or propose an alternative clinical system. Rather, it maintains that oncology remains indispensable for managing biological disease, while arguing that effective oncological practice also requires patient's existential orientation and capacity for meaningful life after diagnosis and treatment. In this way, it

re-situates biomedical intervention within a wider ontology of the human person in which cure refers to biological stabilization, while healing refers to the restoration of existential and relational wholeness. This distinction allows for a more comprehensive understanding of therapeutic success that includes but is not limited to biological outcomes.

The contribution of this study is therefore conceptual rather than clinical. It reframes oncology not as insufficient in its scientific domain, but as limited when considered as a total account of human healing. The paper, by integrating hermeneutic philosophy, medical anthropology, and African relational ontology, argues that cancer care must be understood as addressing both biological disease and disrupted human worlds of meaning and relation. This expanded horizon does not diminish biomedical science. Instead, it situates it within a richer account of what it means to care for a human being. As such, the article advances the claim that healing in cancer care involves more than survival or disease control. It involves the restoration of a livable human world in which persons can again participate meaningfully in relationships, identity, and existence.

In this sense, Afro-regenerative care articulates a broader vision of medicine in which scientific precision and relational meaning are not opposed, but jointly constitutive of genuine care. Afro-regenerative model of cancer care is, thus, an integrated ontological model of care in which cancer treatment, interpretation of illness and restoration of the person are treated as co-

constitutive dimensions of one therapeutic process. It affirms biomedical oncology as indispensable for the control of disease, while also holding that genuine healing involves the reconstruction of meaning, agency and relational existence after the disruption of cancer. The aim is not to weaken oncology's scientific foundations but to deepen its human horizon. Cancer care becomes most adequate when it treats the tumour without losing sight of the person, and when it pursues survival without neglecting the restoration of a livable human world.

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