FLYING A DREAM
Rajiv Gandhi Cancer Institute and Research Centre
RAJIV GANDHI CANCER INSTITUTE AND RESEARCH CENTRE

Flying a Dream
Sometimes I feel quite distinctly that what is inside me is not all of me. There is something else, sublime, quite indestructible, some tiny fragment of the Universal spirit. Don’t you feel that?

ALEKSANDR SOLZHENITSYN, CANCER WARD
Preface

Foreword

Before RGCI: The (Im)patient Voice

RGCI Genesis: A Cry for Help

RGCI – An Overview: Why the Star Shines

Pathology: Sliding the Block

Tumour Board: The Growth of Symphony

Multi-modality and Sub-speciality: The Larger in the Smaller

Clinical Trials and Basic Research: A Trying Time

Radiation Therapy: Beaming Radiance

Diagnostic and Interventional Radiology: Frequency in Matching

Paediatric Oncology: Giving ALL to It

Bone Marrow Transplant: Perfecting the Match

Robotic Surgery: A Programme for Precision

Palliative and Preventive Oncology: Cloaking the Dagger

Stories from the Ward

1. Patient Counsellor
2. The Courage to Test Positive
3. The Undying Spirit
4. Feathering an Ailing Nest

Milestones

Governing Council

Acknowledgements
The Rajiv Gandhi Cancer Institute and Research Centre is a shining example of an NGO supplementing government efforts in providing quality healthcare to citizens of India. Within a short span of 17 years since its inception in 1996, RGCI has attained commendable stature as one of the finest cancer centres in the country, treating 20,000 in-patients and 150,000 OPD patients annually.

Whilst we accept that experienced doctors and state-of-the-art equipment are pre-requisites of a good hospital, it is the DNA of our institution that is responsible for its practices, culture, ethics and the humane way in which we serve our patients. We are proud of what we have created. It is a product of the vision of our founders, sincerity and dedication of our doctors, nurses, support and management staff and many individuals and corporate entities who have donated generously. Our centre is a living testimony to the fact that a small group of people driven by a strong passion to serve the society can dream the impossible and create a world-class institution.

In order to capture our journey to date and express our gratitude to all those who played a role in creating RGCI, the Governing Council decided to assign the writing of its living history. In this context, I would like to make a special mention of Mr KK Mehta, who was the driving force behind the creation of RGCI and the spirit he invested it with.

Let me take this opportunity to reiterate our commitment to continuously improve and serve the society in the field of cancer care. Much remains to be done. It would seem that despite the substantial increase in cancer care facilities, the gap between demand and supply is forever growing. We, therefore, plan to double our existing capacity over the next three years. At the same time, we need to improve our processes of engagement with the patients while retaining the culture and values we have been fortunate to inherit.

On behalf of all members of the Governing Council, I would like to thank Ms Bhavana Pankaj for her painstaking research, and the lucid, readable style of her writing. I hope this book will serve as an inspiration to all of us.

Rakesh Chopra
Chairman, Governing Council, Indraprastha Cancer Society
Everything starts with an idea, a concept in the mind. A dream is shaped by action. Actions become reality by sincerity and hard work.

People say miracles happen to those who believe in them. To me, every hour of the day and night is an unspeakable, perfect miracle. The power of faith and the strength of hope are always there to light our way. Today, and in the days to come, let us believe in our hearts that miracles do happen. One example of such a miracle is the Rajiv Gandhi Cancer Institute and Research Centre which was conceptualised by me in 1990 when a few like-minded people such as AVM HKL Kapur, ACM OP Mehra and Mr OP Nayar joined hands. The Rajiv Gandhi Cancer Institute and Research Centre saw the light of day on 1st July 1996 with its soft opening by Mrs. Sonia Gandhi.

Looking back, I thank God for a good life. I believe He is ever close for those who quietly, day upon day, make an important contribution and bear a message to a wide range of people. What a testimony their lives become when they live in such a way! Their joy comes not from riches or from the praise of men, but from doing something worthwhile. It is only doubled when it is shared.

Seventeen years on, the Rajiv Gandhi Cancer Institute and Research Centre is a leading 302-bedded cancer hospital of North India, with state-of-the-art facilities and technology-savvy people. It now houses eleven modular operation theatres, an ICU, a well-equipped lab and a blood bank with component facility, interventional radiology and PET-CT machine, the latest radiotherapy machines like Rapid Arc (IGRT), TrueBeam, the Paediatric Oncology Department and BMT unit. The vision of the members of our Governing Council has been to offer comprehensive cancer care at an affordable cost. It is our constant endeavour to improve the quality of cancer care.

With this book in your hands today, the Rajiv Gandhi Cancer Institute and Research Centre recalls 17 years of its journey – of growth from infancy to adulthood. It encrypts histories of patients and of the institute that has been built with love and labour, care and compassion. Our people – patients and others we work with – are not merely numbers or contacts. We have built relationships with them. For many of our doctors, nurses and staff, the institute is not just a place of work. It is their identity, their second home. Care with empathy has been the USP of those who founded the Rajiv Gandhi Cancer Institute and Research Centre.

The book eloquently captures the emotional journey of many cancer survivors. The author has opened her heart as she takes us beyond the disease and helps us feel hope, strength, peace and healing.

The powerful essays on the Rajiv Gandhi Cancer Institute and Research Centre describe the hope and courage of our cancer survivors and their families. As a founder member, I am humbled every day by the bravery that our patients display. May the sun shine upon them, may the light within them be their guide always.

It takes strength to put one’s trust in someone or something when life batters your heart and soul. We try and live up to the founding principles of ethics and empathy as much as we can every single day of our work at the institute. That makes me optimistic of continuing to be worthy of our patients’ trust. This institute is not just a building with splendid machines. It is a hospital with a sound heart. Mine is only a small contribution to this project. But I pray the Rajiv Gandhi Cancer Institute and Research Centre will continue its journey towards excellence in cancer care... and that we will be in our dream, awake.

KK Mehta
FOUNDER AND PRINCIPAL ADVISOR
I am a survivor... I was diagnosed positive for cancer. ‘Positive for cancer’ – sounds strange doesn’t it? When I first heard it, it was as though a death sentence. Shock, panic, helplessness, hopelessness, denial... There must have been something wrong, I thought. Perhaps, they mistakenly gave me someone else’s report. I ate right, lived right. Why would I have cancer? Had I done something for which this was payback time? Was it my bad karma? I had dealt with the daily tensions of my world as well as I could. Was it something for which this was payback time? Why me?

It occurred to me much later that the question to be asked was ‘why not me?’ What had I done to deserve all the good things of life while all the bad ones happened to others? Back then, those around me were sympathetic or despairing, giving me the end-of-the-road look. Their eyes mirrored sympathetic or despairing, giving me the existence sometimes pulls them in two directions at once.

**June GoodField**

In hindsight, it was hastened because that was the only way I could have moved on.

But what should I have moved on to? Was there a hospital which could tell me what was happening to me? Were there doctors in these parts who could treat cancer? Who was the best for me? I had questions – but they seemed to have flown out of the window of reason into an unknown sky of fear. I frantically, sometimes resignedly, looked for as much information as I could – from books, friends, doctors. I needed to. But there were so many facts, figures and feelings. I was overwhelmed.

As I moved from one place to the other, I looked for cure and care. But the prognosis was poor. Government hospitals were inundated with patients. A poor breast cancer patient had to camp with her family on the road outside the hospital. There wasn’t a room that could house her for the duration of her radiation cycles. It took weeks before a diagnostic investigation happened. Not many doctors seemed to have the time or the inclination to address the distress, fear and anger of the stricken.

Till about less than two decades ago, there were no private oncology services in North India. Even today, some of the finest oncologists are wary of practising in a government hospital. I knew little about the machine. But the man behind it oscillated between benign indifference and outright apathy. An unlettered man from the Hindi heartland who had lost his young son was shouted at and turned away by the technician for not keeping his treatment date.

Most government hospitals in Delhi had radiation facilities but none had a qualified surgeon. Radiation doctors gave chemotherapy. General surgeons did cancer surgery. Could they tell if a breast tumour they had buried under their scalpel wouldn’t come alive in the bone at a later date? Medical oncology as a separate stream was non-existent except in the Rotary Cancer Hospital. Not one private hospital had a well-established oncology department. And this was in the capital city of the country.

I remember going to a breast clinic on the fifth floor of a government hospital – a makeshift place without even a washbasin for doctors to wash their hands in. They were dealing with us – men and women vulnerable to infection and illness. A group of enthusiastic volunteers got a portable basin and some antiseptic. But it wasn’t merely the immunity that was compromised. It was distressing to see a husband refusing to sign papers for the surgery of his wife because he didn’t think she was going to live anyway. Women were examined in the open, in a room bursting at its seams. Cancer had robbed human dignity as well.

I was told if I landed up with the radiation man, he would convince me his x-rays were my only hope. The medicine man would tell me chemo was the magic potion... magic that was inextricably linked with toxicity and could push me deeper into the abyss. No one realised if cancer was operable, the cheapest method was, in fact, surgery. There wasn’t a way to bring these three men together in empathy with me, so they could comprehend my need and work together for my healing.

Voltaire had said, “Doctors are men who prescribe medicines of which they know little, to cure diseases of which they know less, in human beings of whom they know nothing.” I must be pardoned for agreeing with him at the time. I, sometimes, felt like I was just another case, a stage III cancer; as though my need and work together for my healing.

Many of us with tumours of the breast, liver, colon and lung needed a combination of therapies. Was it possible for the men of medicine to see the patient as ‘our’ instead of ‘my’ so they could decide what was the...
best for him and in which order? From the many permutations and combinations, which would give him the best survival or the least side effects? If both surgery and radiation in early tongue cancer could give equal survival chances to a teacher, should she have had to undergo an operation simply because she went to a surgeon first and lose her speech? Wouldn’t radiation be the preferred option? Wasn’t it incumbent on a radiotherapist to tell the patient to drink lots of fluid before and after therapy? Shouldn’t the medical oncologist have told the woman with breast cancer to have a hormone test because her treatment depended on it?

My questions, weary and afraid, came back in droves. I needed to reclaim myself from fear. I needed someone to hold my hand and give me my options, someone to tell me what was possible and what I could expect. But there weren’t many who said to me that everything that could be done would be done for me. The dialogue that enables doctors to look beyond their individual domains was missing. A roof which housed all that a cancer patient needed was absent. No one facilitated alleviating symptoms when the underlying disease was beyond cure. The surgeon, his job done, told the patient she could go, leaving her to providence and prayer. The radiation therapist wasn’t any different. Medicine was limited to a few drugs and the side effects could kill if the tumour didn’t. The doctor did not know what happened to his patient once she was discharged – how long she lived, when she died.

An oncologist would later tell me he wished diseases could read books. But since it was left to the former to do so, a surgeon must rely on his intuition and experience rather than the prescriptive formula of a book, an MRI or CT scan, to judge if a stage IV oral cancer was operable or not. It was crucial that he makes an accurate decision before he made an accurate incision. I cannot deny there were men who knew when to cut as much as they knew how to cut. But, sometimes, I also saw the sharp blade of eminence blunted by its own overuse. The desolation of cancer territory needed a seeding of clinical capability, of care so that the patient got a rich, productive life.

As I write, I realise that in my voice are the voices of several battlers – the sacrificed, the survivors, the caregivers and the doctors who wage a proxy war on cancer and endure the cellular onslaught nearly as fierce for them as for their patients. But every desert has its oasis. I did my time in cancer. It taught me, as a co-survivor says, “to find a new meaning to life and flower in a changed environment... and separate the wheat from the chaff.” I was fortunate I found good doctors and healers – some at hospitals, others closer home and at work. I survived, as did others who were struck by the maverick disease. But many did not.

It was urgent that the war facilitated a kind of homeostasis in cancer care. Like the scar tissue that makes the body more resistant to the injury that caused the scarring, the conspicuous absence of a caring and integrated facility needed a corresponding manifestation of itself. It needed a “natural recuperative mechanism but in which the outcome is more likely to be a lasting change that makes the organism better adapted to future changes.”

I would hear years later the voice of a fellow survivor, separated from me by continents, brought closer to me by cancer. “Cancer scars are physical mutilations of and on the body; but, more than that, cancer scars the psyche, the soul, the spirit. The ‘me’ before cancer is not the ‘me’ after cancer. Nor can these identities always be sutured.”

We, in North India, needed someone who could sew up as best as possible our ripped identities.
I tell people I’m too stupid to know what’s impossible. I have ridiculously large dreams, and half the time they come true.

Debi Thomas, Figure-skater and physician

He, probably, had a sense that his dream, if anything, was large. His friend, the late DN Sondhi, helped him understand the other half of the expression. It was ridiculous too, no, insane to imagine that Kanwal Krishan Mehta could build a cancer hospital with 50,000 rupees in his pocket.

But Mehta Sahib, as he is known now in the corridors of the Rajiv Gandhi Cancer Institute (RGCI), was, perhaps, a man of mediumistic abilities. “One can conceive of a project,” he would say. “Its success depends upon the Lord alone.” And so he seized the moment as the nebula of a cancer hospital took root in his mind. His dream seemed to be taking its first steps to stand like the hero at the centre of a story that had begun to write itself around the early eighties.

The Delhi branch of the Indian Cancer Society (ICS) was up, and running out of a barsati in Defence Colony. Mehta Sahib founded it in 1984 before he retired as General Manager with Siemens India. Men like VP Mehta and, subsequently, OP Nayar, who like KK Mehta, had also retired from senior positions in public and private sectors, had taken their chairs at a couple of musty office tables.

A driver and a stenographer who was thoughtfully called ‘secretary’ completed the picture.

The ICS, Delhi, had the blessings of the late Dr DJ Jussawala who was then Director of the Tata Memorial Hospital and founder of the Indian Cancer Society headquartered in Mumbai. The NDMC had given them space on Babar Road. A cancer detection centre was making waves with a mobile van, doctors and some robust detection activity. Several such centres in North, West and South Delhi preceded and succeeded the one on Babar Road. Around that same time, Jyotsna Govil was relocating from Bombay to Delhi. She had worked with the Indian Cancer Society, Mumbai, for a couple of years. It was Dr Jussawala’s wish that she bring her experience to the energy of KK Mehta as they set up the Delhi chapter.

People drew together – somewhat in the nature of cells becoming cells becoming more cells – omnis cellula e cellula e cellula…

A committed group not only put itself to the task of cancer detection anchored in St Stephen’s Hospital but also started making awareness talks with interested groups of men and women. Cancer was at the time, what a writer calls, the most “relentless and insidious enemy” of all human disease whose cure was a “fervent hope”. North India, then, was singularly devoid of a facility that could battle the disease. It was also devoid of hope.

It was on one of those days when Mehta Sahib, Mr VP Mehta, his wife Raji, OP Nayar and Mrs Govil sat around their office pondering over the medical blank. “An elderly lady barged into the room and shouted the hell out of me,” remembers Mrs Govil. “You have destroyed us. You have told my husband he has cancer. Now you also tell me what we should do about it. Where should we go?” There were no easy answers to that question.

That was 1985 – and, perhaps, the first time the office-bearers of the Indian Cancer Society, Delhi, started thinking about what it meant to have cancer in these parts of the country.

Detected positive, people ‘died’ more than once before getting to the Memorial Sloan Kettering Centre, Manhattan, New York if they had the means, or Tata Memorial Centre, Bombay if they fell short. Government hospitals, including Safdarjung, AIIMS and LNJP, were plagued by problems inherent to government hospitals – mediocre manpower and middling machines. Hardly any had qualified cancer surgeons even though cancer surgery had existed in Safdarjung for 40 years. Barring the brain, most surgeons were operating on all kinds of cancer such as thorax, abdomen, urinary tract and head and neck. This was true for radiation oncologists as well. Except the Rotary Cancer Hospital, there
wasn’t another hospital that had a medical oncology department. While Safdarjung Hospital had surgery, medicine and radiation oncology, the three streams did not have their own specialists. Radiation oncologists also administered chemotherapy – as they do even today. While the Dharamshila and Batra hospitals gave chemotherapy and radiation, none of the other private hospitals had well-established oncology departments. Not many saw that surgery could be the least expensive method if a tumour was operable. Perhaps, and unfortunately so, it appeared to be more like a fractious battle within the three modalities than a joint war on a common enemy.

The frenzy of the woman who came to the ICS office barsati that morning was truly laced with an existential question. After detection, what? Was there a cure for cancer? Who in the city could fight, or at least try, to fight it? What would be the ravages of this battle, and at what cost?

The diagnosis of cancer itself was, and in some manner continues to be, like the pronouncing of a death sentence. Cancer had been raiding urban city lifestyles in the manner only of a death sentence. Cancer had been raiding, and continues to be, like the pronouncing of a death sentence. Cancer had been raiding urban city lifestyles in the manner only of a death sentence. Cancer had been raiding, and continues to be, like the pronouncing of a death sentence.

By mid-eighties, Mehta Sahib had facilitated the setting up of the Institute Rotary Cancer Hospital with the help of Rotary International and then Union Health Minister Dr Karan Singh, both of whom donated 50 lakh rupees each to serve cancer patients from anywhere in India. But the centre had neither the necessary equipment nor trained doctors and caregivers.

The desperate cry for therapy had started ringing in the corridors of care. Time was ripe for a full-fledged cancer institute in the city of Delhi.

The Birth of Indraprastha Cancer Society and Research Centre

The birth of individuals and institutions is a complex, if not miraculous, process. A tiny seed finds a lodge in the womb. It is nurtured in many ways by many hands. Over a period of time, it develops and takes shape before the pain of labour culminates into its manifestation. It is incredible how from apparently nothing comes ‘some’ thing – and how little resemblance the two may eventually bear… on the outside.

Today, RGCI, or ‘Rajiv Gandhi’ as it is best known, is recognised as one of the finest exclusive, multi-modality cancer care institutes in the country. Apart from the Tata Memorial Centre in Mumbai, it is the only one of its kind in all of India – a 302-bedded hospital with state-of-the-art facility exclusively for the diagnosis and treatment of cancer. It has, so far, registered over a lakh and half patients from India and countries like Nepal, Sri Lanka and Bangladesh. But facts and figures, however worthy, must be used, as Andrew Lang recommends, as a lamp-post – for illumination, not support.

Long before RGCI, though, the Indraprastha Cancer Society was formed with the express purpose of starting a hospital. The desire to build a hospital had taken root when this group of ‘seers’ was still part of the Indian Cancer Society.

In August 1989, two acres of land had been allocated under the name of the Indian Cancer Society. Mehta Sahib and his friends went to AVM HKL Kapur, then Lieutenant Governor of Delhi and ex-officio chairman of the Delhi Development Authority. The dream of the hospital needed reality to become reality, he told the AVM who ensured the land was sanctioned to them.

It was no coincidence that the AVM too had been nursing a strong desire to see a cancer hospital in Delhi. The healthcare facilities in the capital city were abysmally low. He wanted to facilitate anyone who could provide medical facilities to a burgeoning population. Pratap Reddy of Apollo Hospitals, VIMHANS and several other private hospitals would get land around the same time as the Indian Cancer Society.

The wife of the vice-chairman DDA Cecil Noronha and Mrs Govil who had been fellow teachers once upon a time got Mr Noronha to help push things. Every brick was adding up to laying the foundation of the dream.

But bricks need cement to hold them together and, ideas, currency for their realisation. They had the land, but no money to lease it. Mr RN Bansal, former member of the Company Law Board and already part of Mehta Sahib’s host of visionaries, suggested to the latter that they call on the Chairman of Indian Oil, good friend and old associate in the government.

“Three days and a couple of letters later, we received our very first cheque of Rs 38 lakh signed by Mr SK Khosla. We finally had some ground below our feet,” Mehta Sahib recalls.

By this time, most of the group that would later become the founder members of the Governing Council of the Indraprastha Cancer Society had come together, including SK Khosla, KK Mehta, VP Mehta, Jyotsna Govil, the late DN Sondhi, Madan Aggarwal, MS Mathur, OP Nayyar and RN Bansal. Opinion was united that they needed funds to raise the hospital. They also needed friends and goodwill. They needed to knock at people’s hearts – a door that would open countless others.
Delhi, then, wasn’t the urban jungle that it has become in the last two decades and religion, particularly in Old Delhi, was still a good word. The late Ram Kumar Maheshwari, a cloth merchant from Chandni Chowk, had gained a reputation for organising huge religious assemblies and katha weeks. A deeply devout man, he was an eminent philanthropist and ‘master at garnering chanda’, as his son and current secretary of the Indraprastha Society Pramod Maheshwari jocularly puts it.

Mehta Sahib – his entire being acutely centred on realising his dream as it were – heard of Mr Maheshwari. The next thing they knew was a week-long Bhagvat Purana Yagya to raise funds from the people. The latter got Rameshbhai Ojha to perform the Yagya on the Red Fort grounds. “We told the devotees we were raising money for a cancer hospital,” remembers Mr Mathur, a former HSBC man and member of the Governing Council of the Indraprastha Cancer Society whom Mehta Sahib knew since the time the latter held an account with him. “Every day after the arati, we would take our small tin canisters around. People put in 10, 20, 100 rupees, and some 25 paise. Even 10 paise was precious for us.” Indeed, for it was a sacrifice made voluntarily for the larger good in the best traditions of the Orient.

“Staff appointed by the Punjab and Sind Bank counted the money and handed over to us 36 lakhs rupees at the end of the week,” recalls the late Mr Sondhi, Chairman of the Fund-raising Committee, who together with Mehta Sahib organised for 20 television sets to be installed on the Yagya grounds. Mr Maheshwari, who would hold office as one of the founder members of the society, organised along with his other business associates, a free kitchen for the devotees for the entire duration of the katha.

The Yagya of April 1992 set in motion a series of fund-raising concerts and events between 1992 and 1996. Mehta Sahib and his dedicated associates managed to put together what would have been a princely amount of 1 crore rupees that came in from music functions by distinguished artistes.
such as sarod maestro Ustad Amjad Ali Khan, Anup Jalota and Ghulam Ali. Mehta Sahib’s son, Dr Anil Mehta, chipped in with 5 lakh rupees and more followed his lead. Mr Sondhi initiated ‘Donate a Brick’ coupons of 250-rupee denomination and invites to the Anup Jalota show for 500 rupees each. He was Chairman of the Morning Walkers’ Club at Delhi’s Lodhi Gardens and Siri Fort. His walking companions, who included industrialists, politicians and the city’s high-brow, bought and sold the coupons. The Anup Jalota evening at the Siri Fort auditorium sold tickets worth 20 lakh rupees.

The silver merchants of Chandni Chowk – galvanised by Mr Maheshwari – lent a sparkle with a lakh or so. Business groups such as Om Sinduri and the SJ Jindal Trust donated several lakhs in cash and kind. Public sector undertakings, like the VSNL, Burma Shell and Bharat Petroleum, and many individuals dug deep into their pockets. ACM Mehra pushed for two tranches of 25 lakh each from the ONGC.

Finally, Mehta Sahib approached Managing Director of the Housing Development Finance Corporation Renu Karnad. The cause was noble, she admitted, but the bank needed the ONGC’s sturdy bank loan was absolutely essential. The funds were all but gone. The Indraprastha Cancer Society wanted to know who would be responsible should the group default on repayment? The chances of the German government clearing the loan were bleak. Their hands were tied because their parliament allowed no give way. The chances of the German government were bleak. Their hands were tied because their parliament allowed no give way. The German ambassador. Then Prime Minister PV Narasimha Rao would also put in a strong word during his visit to Germany. They promised to do their best. Hanging tenuously between a yes and a no from the German parliament, the two men in a rocky boat awaited an answer.

It came a few days later. In an unprecedented move, the German government sanctioned a soft loan of 12 million DM to the Indraprastha Society. For the first time the Indian

Omnis cellula e cellula e cellula... (Cells became more cells and more...)

Times were hard and money, scarce. At the time the building was coming up, AVM Kapur brought Mrs Sonia Gandhi to the site. Mehta Sahib told her about the facility, their paucity and need for equipment to launch the hospital subsequent to which the two men decided to return the visit – this time with a request for funds. A cancer care facility was critical in North India to everyone who had to go south for treatment. It needed funds, the AVM told Mrs Gandhi. He gently suggested they would name the hospital in the memory of her late husband.

The Rajiv Gandhi Foundation did not have the resources to support a hospital, Mrs Gandhi is said to have told them. But they could give her a proposal and she would put in a word to Chancellor Helmut Kohl of Germany who was meeting her shortly, she promised. The governing council prepared a note which Mrs Gandhi handed over to the Chancellor. Concurrently, Mr Khosla, who was then Chairman of the Governing Council of the Indraprastha Society, suggested to Mehta Sahib and AVM Kapur to visit Germany and see the proposal through.

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It came a few days later. In an unprecedented move, the German government sanctioned a soft loan of 12 million DM to the Indraprastha Society. For the first time the Indian
government stood guarantee to a loan given to a private agency. With a moratorium of 10 years, the loan was to be paid in 30 years at 7.75 per cent service charge in 30 years starting 2006. The sanction, however, mandated that the loan be spent in Germany. Siemens became the project manager. Mehta Sahib’s association with the company facilitated competitive rates to the Society. Soon, medical equipment worth approximately 26 crore rupees was on its way without which the first super speciality cancer hospital of North India would have been but a dream.

The AVM’s tenacity had paid off. He would now successfully persuade Air India to provide free shipment of the equipment from Germany to Bombay and Delhi and the Customs to clear it without charging a penny.

With the political dispensation of the day and the Rajiv Gandhi Foundation having declined to fund the hospital, the move to name the hospital in the memory of the assassinated prime minister had come to naught. But the Governing Council of the Society met to pass a resolution of thanks to Mrs Sonia Gandhi – she had given them vital access to the German government. The hospital was to be called Rajiv Gandhi Cancer Institute and Research Centre.

The wheel, then, was turning. State-of-the-art radiological equipment from Siemens, Germany, was coming in as the best thing yet to the hospital. The hospital pooled in 50 lakh rupees to pick up the first cobalt machine for radiation oncology services. The facility had cutting-edge surgical oncologists who had already joined the hospital. Medical oncology, fortunately, did not need much paraphernalia. But in what was ostensibly yet another irony, the new building did not comply with the radiation-shielding design standards. It needed, for example, thicker, lead-lined walls to safeguard against leakages. It needed rooms large enough to accommodate machines, consoles, tables, trolleys, chairs and couches… And for the umpteenth time, it needed more money. “That’s when Mr Sondhi helped us get a loan of 12 crore from the Oriental Bank of Commerce and we were finally ready to launch,” remembers Mr Bansal.

July 1, 1996, marked the soft launch of RGCI by Mrs Sonia Gandhi. A little over a month later on August 20, then President of India Dr Shanker Dayal Sharma formally inaugurated the cancer hospital in North India in the presence of Mrs Gandhi, the German ambassador, Finance Minister P Chidambaram, Home Minister Shivraj Patil, then Chief Minister of Delhi Sahib Singh Verma and other dignitaries – with 152 beds, 40 doctors, 30 nurses, technical and other staff with all three oncology specialities – surgical, medical and radiation – up and running.

The ridiculously large dream that Kanwal Krishan Mehta had dared to dream with a mere 50,000 rupees in his pocket had come true. That dream today is priceless.
29th June, 1996. Water was scarce. The sole toilet was kept locked and the key secured with Nursing Superintendent Indira Sharma. The little waterfall that was built at the very entrance of what is now the old building hadn’t been operationalised. Mr KK Mehta and some people got into a huddle just a day before the soft launch. Ms Sharma was to ensure that the water would fall to coincide with Mrs Gandhi’s cutting the ribbon. A test run revealed the fall was going to be a washout – it hardly looked like one! It was too late to cut the stones for a real look. Ms Sharma and her team cobbled together some small and large stones and added lots of soap-suds to the water. The soft launch on 1st July was a frothy success – bubbles, foam et al!
A tongue-in-cheek advisory on babies tells the new parent to not look at birth as necessarily a cause for alarm. “The important thing is to keep your wits about you and borrow some money!” The founding fathers of RGCI had on their hands a cancer institute in its infancy and able caregivers who would change the way oncology would be seen in these parts. Eminent oncologists in surgery, medicine and radiation such as Dr KK Pandey, Dr AK Dewan, Dr DC Doval, Dr AK Vaid, Dr Tejinder Kataria, Dr Shelley Hukku and Prof PS Negi were avant-garde witnesses to the beginnings of the institute. They came in from Maulana Azad Medical College and Safdarjung Hospital, PGI, and Pune’s Armed Forces Medical College. Dr Pandey – formerly with Safdarjung and Dharamshila Hospitals – joined as the ‘cancer man’, a surgeon with a formidable reputation preceding him. Dr AK Chaturvedi had prematurely quit a secure career with the armed forces to pursue his passion for radiology – he joined as HOD, Diagnostic Radiology. Dr Amar Nath Jena – the father of MRI in India – came in to introduce dedicated MRI application in oncology and as the very image of science in the service of cancer patients. Some of the best men and women from North India, primarily Delhi, Lucknow and Chandigarh, were already part of the founding fraternity of doctors who would, eventually, select their own teams.

Young men – such as GS Wadhawan primed by Tata Memorial Centre’s Dr Ketayun Dinshaw – joined as the radiotherapy technologist. CP Gupta, who cut his teeth as OT Supervisor at Delhi’s Dharanashila Cancer Hospital, would be the first OT technician. Indira Sharma was the first Nursing Superintendent and KS Rana would go on to head one of the best-kept Records Section in Indian oncology. AVM Kapur, who took over as Chairman after Mr Khosla lost his battle to cancer, used his good offices with Dr Pratap Reddy of Apollo Hospitals who willingly lent Dr Yogi Mehrotra to run RGCI for the first few years. Dr YP Bhatia was brought in from the Jaipur Golden Hospital as Director, Administration. Facilitated by the founding fathers, the two men, between them, would set up the systems, ground rules and guiding philosophy of the new institute.

Well begun was, indeed, half done. But the other half was easier said than done. This was a rare business of its time that ran only on loans – there were no grants given. Those loans had to be returned, salaries paid and running costs to be incurred. Years starting 1996 to 2000 were critical. But the men on the Governing Council were clear about never passing on the burden to the patients.

“We were meeting the cost of operations and managing salaries and bills. We still had liabilities and debts to be serviced,” says Dr Chaturvedi. The institute was in dire need of funds. In what were, perhaps, the longest first four years – the hospital had little income. “We were declared NPA by the bank and had to get the loan re-structured,” Mr Bansal still flinches at the memory.

Rumours were rife of the governing council readying to relinquish and selling to Fortis or Reliance. People were seen walking around the hospital with Mehta Sahib and AVM Kapur trying to assess its worth. “We got just a handful of patients in the first few months. We were sceptical if the institute would come around. May be it will be converted into a hotel, we thought. But our Chairman AVM Kapur was very gung ho – the place is going to run, he would say cheerily and even call for sweets every now and then,” smiles Mr Wadhawan.

There wasn’t a day when Mehta Sahib did not come to the hospital. “...and there was neither a time when he did not think of the well-being of his people nor a day when we did not get our salaries on the first of every month. I remember AVM Kapur even seeking donations for our wages,” recollects Ms Indira Sharma, the first Nursing Superintendent and one of the earliest hands. Senior medical fraternity would release money from their personal funds for salaries to their junior colleagues if the wage money took a while to come. “Never in the history of RGCI have we faulted on salaries,” says a proud Sanjay Bharadwaj, head of Public Relations.

Even though there was a moratorium on repayment of the loan, the German loan would be an expensive proposition. The Society hadn’t taken any hedging against the whims of the forex market. The liability was going to be huge in the days to come. As with the stars, reminds the poet, that we see when it is dark enough, so with men’s ideas. The Governing Council was already mulling plans to bankroll. With the reins in the hands of Mr Sondhi once again, the fiscal horses of the hospital would lope into directions unique for that time.

Mr DB Sethi and he, both old hands at insurance, proposed the very innovative Cancer Insurance Programme in partnership with an insurance firm. The patient-beneficiary scheme would enable enlisting a couple for life-long free treatment in the general bed category in lieu of one-time payment of 5500 rupees. The hospital was to take care of the chemo drugs costing up to 50,000 rupees while there was no limit on non-chemo drugs. “We thought it was such a great idea since it would give us access to instant cash while the payout would be somewhere in the future,” says Mrs Govil. The scheme drew 15,500 members. Each of them was certified as medically fit at the time of joining the scheme and issued an ID card. There was a lock-in period of one year for treatment from the time of the issuance of the card.

The big ticket raised about 6 crore rupees before it was abandoned at the end of 2004. The governing council woke up to the fact that there was a payout and it was increasingly becoming heavy in spite of raising the premium to 7500/- rupees. “Money was critical at the time – we had taken loans at skyscraping rates and needed to repay
them," says Mr Nayar. "Non-chemo drugs were burning a hole in our pocket – much more than the chemo drugs. That’s when we decided to close it down." Fortunately, that would be only in the interim. It wouldn’t be long before RGCI would emerge from its financial crisis and return to its altruistic roots to stand by the nameless people who had stood by it in its time of crisis. The scheme was revived, this time with somewhat altered rules. It would continue to service only the initial 15000-odd members. Everything, including consultation charges, cost of bed and investigations was gratis except for medicines. Over 4 crore rupees – 70-80 lakh per annum – have been spent on more than180 beneficiaries with 25-30 of them coming in for treatment every month.

But back in 1996-97 in times of crunch, Mr Sondhi partially turned it around with the Cancer Seals Project. He approached the Department of Posts in the Ministry of Communication for approval to affix on all types of mails cancer seals. The department acceded within 10 days and 23rd June 1997 saw cancer seals introduced for the first time in India to raise funds for the cause. The man went to corporate entities asking them to sponsor the seals. M/s Bon Ton Opticians would take the lead, shell out the first 1 lakh and then President SD Sharma would release the seals.

In 1998, Mr Sondhi met Chairman of Punjab and Sind Bank and the two men found a common chord that would sustain the project for times to come. Both were intimate with cancer – the former had lost his daughter to cancer and the latter, his mother. Mr SS Kohli agreed to donate 25 lakh rupees to the project followed by another donation of the same amount the following year. More nationalised banks, including old associate Oriental Bank of Commerce and Punjab National Bank, came forward with their endowments, the latter at the behest of AVM Kapur. The funds from the project went into “building the building” as an enthusiastic Mr Sondhi put it; he in turn was enlisting the support of banks and others to contribute to a corpus for patients unable to afford the high cost of cancer drugs.

By the year 2000, the Society was breathing easy. The all expense-no revenue chapter of the hospital was ending. While some pages of debts and advances were still book-marked, parts of the bank loans had already been repaid. The Euro shot up as the rupee fell and the liability of the German loan became far higher than anticipated. The Society is still returning that loan. But word about the hospital was spreading fast. The number of patients registered in the first five months steadily climbed up from 2873 to 30,000 in the fourth year. Close to 80 per cent patients were registered as either from Delhi or with a Delhi address. Many others came from Haryana, Punjab, Uttar Pradesh, Bihar, Rajasthan, Madhya Pradesh, Jammu and Kashmir, Chandigarh and North-eastern states, besides a handful from close neighbours such as Nepal and from as far as Iraq. Today, the figure stands at over 160,000 patients divided more or less evenly between Delhi and other states.

And The Gains

“When your loved ones talk about their cancer, listen. Really listen. Sometimes, it is not what you say, it is what you do. Listening is one of the best ways to show you care.”

It was around the same time as the Delhi branch of the Indian Cancer Society was trying to reach for the stars. Detection wasn’t enough. They were in combat mode. Mehta Sahib had moved the big idea of starting a dedicated cancer hospital. The Bhagwat Purana Yagya and other fund-raising events were under way. For the first time, the dream of such a full-fledged facility in North India looked probable.

Perhaps, the great law of simultaneity was at work. Harmala Gupta, a young woman diagnosed with Hodgkin’s Lymphoma, had returned from Canada after treatment. Therapy there was meant to give succour not only for the body, but also for the mind and the spirit which otherwise wilt in the unforgiving conditions of cancer. It isn’t merely the body’s immune system turning against itself. For the cancer-stricken, the internal environment that nurtures living beings begins to take them into isolation, fear and despair. And, many times, also, hostility. The uppermost thought that Harmala Gupta came back with was to set up an emotional support group in India which lacked a service that could answer “Why me?” but, more importantly, listen.

She met Mr Jitendra Tuli, a like-minded survivor. They would talk about survival issues, of “the period of extended survival after treatment that is perhaps even less well recognised for its traumatic nature. The
Harmala Gupta – an emotional support group made up of cancer fighters, as Dr AK Dewan likes to call Cancer Sahyog under the spreading wings of the Indian Cancer Society was born Cancer Sahyog – an emotional support group made up of cancer fighters, as Dr AK Dewan likes to call them, and caregivers. “Psychological support starts with Cancer Sahyogis reaching out to the patients the moment they walk into the hospital. The Sahyogis have a tough task, which includes guiding the patients on where to start, how to register, how to pay, which department to go, which doctor to see, how to seek financial support if necessary and then there is the hand-holding when the patient or family are emotionally down,” says the Medical Director of RGCI.

Like war veterans, these men and women take the patient by her hand, guide her through her battle and give re-mission a completely new definition.

Cancer Sahyog would become the first in-house support group for RGCI as it continued its good work in other hospitals of the National Capital Region as well. But there was a group of unsung, nameless but equally devoted men and women within the hospital who contributed their bit to making it what it is today. Apart from an able medical coalition, these were people who performed multiple roles as the story of their young hospital unspooled and demanded austerity in its formative years.

“My brief was – maximum output with minimum material and manpower,” smiles Indira Sharma. “I went without an Assistant Nursing Superintendent for 10 years and learnt to be more efficient and a better decision maker.” But long before she would school generations of nurses in the ethos of the hospital, she had been requisitioned to supervise construction, design interiors, furniture, stationery and uniforms, plan signage and set down the passage to move the bodies of the deceased.

person wants to resume normal activity and yet body and mind are not ready to respond. Physical strength is diminished while the mind is full of anxiety, ready to interpret each new symptom as a recurrence of the disease. Problems such as a loss of a missing body part, lost hair... which could be dealt within the confines of the hospital now have to be publicly acknowledged... There are no sympathetic doctors and nurses to turn to except for periodic check-ups... There is no getting back to the way it was... and you have to renegotiate your relationship with the ‘healthy’ world all over again, evolve a new sense of what is normal for you,” says Harmala Gupta in a poignant account of her brush with cancer.

That’s when she met Mehta Sahib and under the spreading wings of the Indian Cancer Society was born Cancer Sahyog – an emotional support group made up of cancer fighters, as Dr AK Dewan likes to call

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almirah, furniture, tables, beds, equipment, life-saving and other drugs before he was asked to take charge of the Medical Records section. GS Wadhawan, now Radiotherapy Technologist, maintained machines and assisted Dr Tejinder Kataria, first radiation oncologist, with devising of radiation protocols. A former school teacher and now OPD Coordinator, Vaijanti Mala joined as receptionist but was more like a mother to clamouring patients every morning. “Till then, processes for all OPDs – surgical, medical and radiation – operated from a common counter and patients came without appointment, each of them asking for their files to be taken out. I would be very happy to help; they were like family and there was a bond I felt with them,” she says, as her eyes cloud over. Sushila J, who was amongst the first people to join Mehta Sahib in the early days of detection activity, screened patients, studied to become a Nursing Aide, campaigned with missionary zeal for the hospital, and learnt the ropes of record-keeping before passing them on to Mr Rana. CP Gupta, now OT Supervisor, took charge as senior technician who ensured that everything from the hand-scrubbing machine to the anesthesia machine was in order. He made equipment lists and surgery boards, helped colour code drugs and craned his neck for several nights holding up the lights as the engineers screwed them on in the operation theatre...

Each of these lights ~ 1200 people at the moment – that have been turned on in the last 16 years has today fused to become one star. As the process of fusion carries on, the star continues to shine – radiating hope, warmth and care – on lives darkened by cancer.

And the star shines for reasons more than its photons and gamma rays.
“How are you?” The banal question gets a shine every Monday, Wednesday and Friday of the week. A kindly looking man is seen going up and down the general and private wards of the old and new buildings of the hospital. The latter also has rooms on the third and fourth floors. Together they house 300 in-patients at any given point undergoing therapy, procedures or post-op convalescence. The man, along with the Medical Superintendent, Chief of Nursing and heads of Housekeeping and Dietary departments, meets the patients individually. He inquires after their well being. He asks if they have any problems concerning any of the departments. He shares a joke or two and tries to bring some sunshine to the bleakness of their lives.

For once “How are you?” is not a perfunctory question. Neither does it go begging for an answer. The nurse wasn’t careful with the PICC line. The bed-sheet needs to be changed but no one’s listening. The night-duty doctor wasn’t there for our sick child. We were scared. The water tap there has been leaking for many days. Can you do something about the food?

The man doesn’t balk at the answers. He listens keenly. He listens with the intent to understand, not with the intent to reply. The men and women who he listens to are a devastated lot. They are trying to make meaning of their upheaval. They need comfort. They long, perhaps, to go back to the ordinariness of their life. In his listening, they seem to make that journey.

“I am no counsellor. But when I talk to a patient from the bottom of the heart and try to counsel him, for him it is coming from the CEO of the hospital. He is traumatised on many counts. There is always a possibility of knee-jerk communication between him and the caregiver. Some or the other issue is bound to come up. But if I can listen to him and light up even a few moments for him, it gives me a sense of purpose too.

When you run a cancer institute, you cannot be an armchair administrator. You must have your ear close to the ground. You need first-hand understanding of what the patients want and what they think of you. About 80 per cent of those who come to us are repeat patients. They come again and again so that a rapport gets built with them and their families over...
time. The morning visits give me small but significant insights. I come back with ideas on how best to serve,” says RGCI CEO DS Negi. The visits bring him face to face with people every day who mirror the glitches. A patient had to wait for a bed even when it was available because of some miscommunication between the admission desk and the ward. Or there was a time gap longer than 30 minutes – that is the longest it should take – between admission and start of medication. “It happens, even though rarely. We try and sensitise our staff – housekeeping, admission, front desk, ward staff, nurses, lab... These are ailing patients, in a very delicate state of mind and body. But we also have 1200 people here – ward boys to doctors – from different cultural backgrounds and departments. We emphasise soft skills training courses too. But it takes time to build a culture in an organisation. In our own way, we try to constantly rectify and mend.”

Every twice a week on Tuesday and Friday, surgeons and physicians from all modalities also hold clinics after 2 pm for very needy patients who can get their OPD cards made for only 5 rupees. It was early days for the institute. An elderly patient had a neck surgery and developed complications. The leak would take a long time to heal, the surgeon said, and told the family he would repair it later if necessary. She was discharged with the feeding tube. Four weeks down on an early morning, she returned bleeding from a vascular rupture. The surgeon rushed to the hospital. She was shifted to the ICU but died in front of him. Three months after, the surgeon saw the daughter of the deceased in the general OPD. He thought perhaps she had come to complain. He was left speechless when he heard, “You did your best – I saw it. In spite of that I lost my mother. Today I have brought my sister-in-law to you. Can you do something for her?”

It’s been 16 years since the incident. But the surgeon remembers like it was yesterday. “For a doctor there is no greater compliment than a family bringing back another patient even after they have lost someone – and that someone happens to be their mother.” It speaks of the trust a patient places in a hospital to be humane and honourable. And it speaks of a tradition that forbids trading in distress and upholds the ideal of service, most times done anonymously.

Most of the founding fathers of RGCI knew intimately the blight of cancer. Some had helplessly watched their loved ones slip away. Some fought hard to save them. Some others lost their own battle. Still more would fight it in the times to come. Their hearts carried the pain of many others when they were drawn to the idea of building a cancer hospital. It was “a pain intensified by imagination and prolonged by a hundred echoes.” It wasn’t accidental that everyone associated with RGCI – doctors, nurses, technicians, administrators – was of the same mind. The idea of the institute may have been born of a deep, individual desire. But the solitary desire as it voyaged drew to itself similar, even identical, aspirations. Inherent in it was the larger need of the times that ensured its fulfilment.

Empathy formed the founding brick of RGCI. Administrators, clinicians and nurses knew they would have to share the victories and losses, survival and resistance, wounds and death inevitable in cancer. As drivers of the founders’ vision, they knew they had to find a way out of the pits and reach out with deep care and loving concern. The sanskara of service and care, like the invisible DNA strands, tied everyone together – and continues to do so, replicating with as much fidelity as possible. Yet, it has found visibility in the men of the institute, its machines, the systems and processes and the advances it has made in the last few years.

“It’s not just the disease that needs looking after – the journey is more difficult than that. How comfortable is the patient emotionally, financially and physically with regard to her social situation? There is loss of job, and of self-esteem... there is anger, denial, pretense, withdrawal and vulnerability. In such circumstance, every little thing counts – a fund, a financial discount, an ICU charge nearly at par with general ward cost, a kind word… It feels good to know that we are part of a hierarchy that needs only a small hint as to the patient’s condition before it quietly does its best to facilitate her. This isn’t just her journey. We try to walk with her. And that is why we have walked this far in 17 years. Unless the fundamentals are correct, good outcomes are only a distant dream.”
It is tough – jis par beet rahi hoti hai, wahi jaanta hai. ‘Sab theek ho jayega’ sounds hollow and words of consolation seem terribly inadequate till such time they find strength within themselves,” she says.

And yet, that’s what the OPD coordinator has been doing for most of the 16 years she has been here – using words to palliate.

Mr Kapoor went through a bone marrow transplant. She still remembers his CR number. His wife would accompany him every time he would come for a follow-up. Each time, he would be heard shouting at his wife and the two would have a showdown at the reception. People simply stood there and watched the spectacle. But that day was exceptionally bad.

She went up to him and asked him what the matter was. “My wife is forcing me to sit in the wheelchair. I don’t want to, I can walk. And all she does is to cry when she speaks to me.” Vaijanti Mala held his hand and said, “Treat me like your younger sister… and hear me out. Your wife loves you and does not want you to go through more suffering. If you continue to shout at her, she is going to feel worse,” she said and signalled the ward boy to get a wheelchair.

The OPD Coordinator then went to the porch where Mrs Kapoor was waiting. “I know you cannot help your emotion. But try to be strong and strengthen him too,” she said to her as the driver helped the gentleman into the car.

“I cannot forget the look on his face when he reached out for my hand and held it for a while,” she says. Today, he is fine. He never fails to meet her whenever he comes for his treatment. Research to radiation, drugs to their trials, prevention to palliation… of RGCI. But many names lost to the heaping records – of RGCI. But Pernaaz could have well been one of the many lost to the heaping records – over one lakh and counting – of RGCI. But she isn’t. Not only is her name recalled with facility, but also with fondness – as though she is someone dear, someone who belongs. And she isn’t the only one.

Young Shabnam Shafi brims over with emotion for the treating doctor, the nurses and counsellors who held her hand during the treatment of her baby sister Tamkeen. “Such a big hospital – I felt the absence of an elder from the family. But our doctor gave us such courage, gale se lagaaya, sir pe haath rakha… the nurses would stand there holding the pan when Tamkeen threw up… aise log kam milte hain aaj ki duniya mein.”

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Chief Security Officer DP Tyagi offers an enthusiastic meaning to the word ‘service’ as he recounts the story of Pernaaz. Pernaaz and her husband had just alighted in front of the hospital gates when a couple of boys on a motorcycle snatched and sped away with her bag, money, passports, papers et al. “Fortunately, the bag came back with all the papers intact. As I sat them down, we found Pernaaz had come for her chemotherapy post her mastectomy at RGCI. I asked her if they had had anything to eat. No reply. I asked her again – beta, aapne khana khaya? She knew Hindi but when she chose to not reply. I asked her husband. He indicated to us they hadn’t because every bit of their money was gone along with that bag. I spoke to our F&B team which offered to host all the three meals for the entire period of their stay. Pernaaz’s clinician Dr Sunil Gupta, too, decided to forgo the consultant’s fees. We just intimated a few people and before we knew it, Sister Krishna Bhatt in Nursing, Mamta in Administration, and Dr Lakshmi in Casualty who keeps donated medicines, Dr Jaiyopal Sharma and Dr Indu Aggarwal in Preventive Oncology and some others quickly put together over a lakh for her medicines she could take back. Finally, one of our senior administrators quietly wrote a personal cheque to fund their journey back home.”

Shabnam speaks for Ashutosh Dixit, Nikesh, SK Anand, Raunaq, Nandini Pradhan, General Lakhera and several other patients who were spoken to in the course of writing this book. Each of them suffered their own ordeal but emerged united in their feeling. “A nurse puts in eight hours of work – by the patient’s side or elsewhere. That is only her duty. But if she can spend a few minutes talking and listening to him as she does her work… us se pyar se baat kar to uske andar ka bahaau kuch bahaar nikal aata hai… those 15 minutes make life worthwhile for her,” says a senior staff nurse.

OPD Coordinator Vaijanti Mala gathers another conversation from the rumbles of time. A young boy with Chronic Myeloid Leukemia returned to Medical Oncologist Dr AK Vaid. This was a long-standing treatment, like most cases in RGCI are. The boy had run out of money, and, also, medicines. By the time he returned to the hospital, the disease had spread. “Dr Vaid said – you should have written to me just one postcard and the medicine would have reached you’. That incident left a deep impression… Many years later, not much has changed. I have seen our doctors helping with free medicines and bedside visits, seeing patients without cards, jumping the queue to see an outstation patient on our request… perhaps the so-called ‘professional’ touch hasn’t infected us yet.”

Indeed, RGCI does not wear the nippy, five-star air on its sleeve. But it has an old-world appeal that is warm and restorative. Its top brass is as accessible as the familiar family elder. Seniors charmingly call their junior colleagues ‘beta’. Doctors pop in for a candy or a cup of tea into administrative blocks. Surgeons hail their patients from the other side of the corridor. It buzzes with a positive vibe in spite of death escorting its every moment. Or, perhaps, because of it.

Old-timers recall Mehta Sahib’s words: Give nothing but the best once you’ve begun the treatment. Research to radiation, drugs to their trials, prevention to palliation… everything at RGCI coalesces in care of the
patient. “RGCI stands out because of its philosophy. A vision of a 50-bed hospital has been emboldened by the intention of its founders. They taught us to be empathetic, not sympathetic,” says Dr AN Jena. “Today someone else is stricken by cancer, tomorrow it could be me. I cannot give relief to my patient; at best I can only manage his disease. But let me not do anything half-heartedly! If I know digging just a little deeper in the MRI that shows a problem spine will give me a clincher, I will dig till such time as I get the final answer. Not doing your very best in cancer is as bad as not doing it at all.”

And so, RGCI negotiates hard for every bit of the consumables because every extra rupee impacts the patient. It houses the only pharmacy in the NCR region that passes on the benefit of 21 per cent rebate on medicines to the patient which in the normal course would go to the hospital. Barring the 20 patented medicines of the 5000-odd, the discount applies to all other medicines. The patient is free to purchase medicine from outside the hospital pharmacy making RGCI the only hospital in the country, perhaps, to allow it. The doctors prescribe a generic but equally effective drug because they understand a poor patient has scraped every penny to get there.

“Lack of money has never kept us from taking in a patient. Most of our patients are in stage three or four at the time of admission. The moment they come, we advise them to enroll with PM or CM Relief Funds following a medical estimate. These funds and other partner schemes are a boon for our patients, 85 per cent of whom pay from their own pocket. A patient in terminal stages or one who cannot afford treatment is given a free bed. As a matter of policy, the hospital gives 10 per cent off to general ward patients on total bills. There are sizeable concessions, for instance, to the patients of bone marrow transplant because the costs run up to several lakhs. The hospital has waived major charges in innumerable cases,” says Mr Negi.

“Removing the upper jaw and palate is a disfiguring surgery,” says a senior surgeon. “I have to give my patient a dental plate or prosthesis so he eats well, keeps his food down and sleeps well. I have to make sure that he doesn’t continue to see the stigma of cure. I’ve got to take my surgery to a logical conclusion – and I cannot compromise in reconstruction only because he cannot pay... and I don’t. My patient is my brand ambassador. His carries a little bit of me, a little bit of the entire hospital as he steps back into the normal world after his treatment.”

Death has its compensation. From it is born an ethical life, which works towards the happiness of fellow beings till such time as everything returns to where it comes from. If RGCI has flourished in the shadow of mortality, it is because an ethical vision has nurtured it. The average modern, corporate hospital has ‘hidden costs’. RGCI has some hidden kindnesses.

Apart from practising a tacit policy on concessions, the founders designed the systems that put the collective above the individual. The earnings of the consultants – all of whom work full time with the institute – are not dependent on the individual amount of work. Irrespective of the number of surgeries done by a surgeon, the money goes into a departmental pool and is shared among the senior consultants. This avoids undercutting, over-diagnosis and ensures protection of the patient against the whims...
based practice,” says the Medical Director. “We don’t give our clinicians fancy fees and luxurious cars,” say the Governing Council elders. “But we give our patients state-of-art therapy. It’s like walking the razor’s edge. Good clinical facility is imperative for quality care. We also need to invest in our people while minimising the patient’s costs. It has taken hard work to retain talent but never at the cost of our patients. Those who agreed with our worldview have stayed on with us. Whether it is the PET CT, Digital Mammogram, True Beam, or CT machine, the surplus goes into procuring the best for our patients.”

That also makes RGCI the best – second only to Tata Memorial Centre today – in terms of cutting-edge technology. A long standing patient SK Anand says, “The man behind the machine matters. I came here looking for my doctor. Today I know this is a hospital which has the most current machines and equally devoted doctors. Skill and technology work in tandem here to get to the most complicated tumours one way or the other.”

State of the art and state of the heart – together as body and soul – have characterised the life of the hospital for the last couple of decades. “Many hospitals have robotic technology today. But they are not able to do many surgeries because the man behind the robot is less than outstanding. Our OPD and IPD patients, number of radiations, surgeries, chemotherapies and diagnostics have increased gradually. I haven’t seen a dip anytime. In 1996, we were riled by doubt if this hospital will run. Today, we have shot the one and a half lakh mark – more patients from outside Delhi apart from 2-3 per cent from other countries. We have kept ourselves updated, studied together and attracted people through ethical, evidence-based practice,” says the Medical Director.

A Vision Emboldened

“RGCI has been fortunate to have some wonderful people at the top. Dr YP Bhatia who was our first Director, Administration told us, ‘See yourself on the other side of the table and imagine what you would like to hear. Empathise with this person. Don’t think your seat gives you the right to talk to people as you want.’ Mr KS Rana, Senior Manager, Records, shares a leaf from memory. The Medical Director remembers, “Dr Yogi Mehrotra, the CEO of a young RGCI, was a man so positive… he would go to each of the patients’ rooms. He knew the clinical condition of each and every patient. He would discuss it with us. ‘Can we do something for a patient? Is there a second line of treatment? Do we need to seek a second opinion?’ And we took it sportingly.”

Today, the diagnostic and clinical wings don’t hesitate in taking a second opinion – not for lack of belief in their capability, but with the realism that is never too embarrassed to hide its mistakes. Personal integrity and respect for competition is driven by the primary desire to sustain life. Dr Mehrotra’s questions have found answers in the institutions of tumour board, multi-modality and organ-specific specialties.

Men such as Dr KK Pandey – who introduced the concepts of multi-modality and tumour boards – were integral to the process of culturisation of RGCI. “I don’t think I introduced any culture or left a legacy. It was a joint effort. But I was the oldest perhaps and, so, I can say my contribution was to bring people together and resolve their differences. The tumour board, for example, was based on the basic principal of facing off three modalities in the interest of the patient. That’s how multi-modal treatment becomes so worthy of practice. That’s how protocols are made.”

Rewriting protocols meant unlearning as well as embracing the best practices followed in the world of oncology care. RGCI led the multi-modality practice, particularly in North India. Eminence was no longer enough. Peer oncologists asked for evidence. “It is a matter of ethical practice, wisdom and morality that doctors here bring up difficult areas or cases instead of shying away from genuine criticism. Backed by the evidence provided by National Comprehensive Cancer Network guidelines, such practice definitely improves the outcome for a patient,” says Head of Radiology Dr AK Chaturvedi.

But evidence did not mean discarding eminence. It meant integrating experience and clinical intuitiveness. No longer now can a surgeon say he will not operate advanced cases. He has learnt there is evidence to prove that some such tumours may be operable. Evidence may give 50 per cent patients good survival with surgery. But he needs intuition to select the other half that will not be benefitted. That sixth sense helps him select a patient who will, in fact, do well with surgery. At RGCI, the team of surgeons makes this selection carefully, within the framework of evidence.

The sixth sense drives nursing care too. Old-time nurses such as Sister Krishna Bhatt and many of her colleagues learnt onco-nursing from senior clinicians such as Dr DC Doval, Dr Ashok Vaid, Dr Gauri Kapoor and Dr Dewan. They worked hard at staying abreast with new chemo and surgical protocols. But Sister Krishna says, “Books don’t tell me about how to get attached to my patient enough to take care of him, or how to counsel the husband of a woman who has undergone mastectomy or a patient who cannot look beyond his own disease to see what his wife is going through.
Ek nurse ek cancer patient ke saath kya aur kaise baat karta hai, yeh kisi kitab mein nahi likha rehta. She is a friend, counsellor, healer, mother… we have cooked and cleaned for our patients during times of emergency. A nurse’s hand, you see, fits every glove.

Sister Krishna Bhatt

Such nurturing is not restricted to patients alone. Among the festivals and functions celebrated at the institute is Onam when RGCI nurses get together to cook a traditional lunch for all heads of department, consultants and other staff.

It all began in 1996 when Mehta Sahib, Lt-Governor HKL Kapur and the medical faculty trooped into the third floor of B block which housed the nurses’ hostel at the time. Young nurses – many of them from Kerala – in customary white saris and flowers in their hair greeted their guests and applied a chandan tilak on their forehead. The Onam sadhya or feast was served on banana leaves. With its steamed rice and multiple side-dishes, the platter rivalled the many colourful rangolis made especially for the occasion. “So impressed was Mehta Sahib with the girls that he gifted them a three-foot brass lamp which is lit at every occasion that is celebrated in RGCI,” smiles former Nursing Superintendent Indira Sharma, who instituted Onam and Christmas celebrations at RGCI so that nurses, too, could find respite from their very stressful work.

The tradition continues even today, as the nurses return, for just a day, to the hospital kitchen instead of their wards and OTs – if only, as always, to serve.

The man in room number 115 was very upset. “You don’t understand. My wife wants to feed me home-cooked food and I want to eat what she cooks... and I don’t care for your rules,” he wept.

Rules had been freshly made in the recently established hospital. One of them disallowed food from outside for fear of being contaminated. For a cancer patient – low on immunity and at high risk of infection – it was only right that the directive be followed. But for a terminally ill cancer patient, home food is, perhaps, also the vital connection with life. It links him up with warm feelings of home and hearth, with security and consolation... and happier times.

The nurse on duty saw that connection – and went beyond the rule. She spoke to the doctor concerned who allowed the man some home-cooked food. Since then, the rule continues to be enforced. But an exception, too, is made every now and then so that the man in the ward finds a brief release from his confinement, and, hopefully, a sweeter taste in his mouth.
Each time the paediatric oncologist saw Ayesha at her quarterly review, she would cheerfully tell the cherubic Afghan girl “Bilkul theek ho jaogi.”

That assurance was the straw the teenager and her father, Nasser Khan, were hanging on to. In 2011, she had tested positive for cancer in her gums. Surgeons in Pakistan offered bleak chances of recovery post surgery – Ayesha would never be able to speak, they said. That brought them to ‘Rajiv Gandhi’ in India. Surgery by Dr Sandeep Mehta and late Dr Himesh Gupta followed six rounds of chemo.

“Beti ka baal chala gaya to woh rone lagi. To uski Ma se phone kar ke bola samjha do, to Ma bhi rone lagi. Mein beti se bola tum bachchi nahin, tum bachcha hui... theek ho jayega. Baal phir aa gaya. Lekin doosri chemo mein phir baal chala gaya. Ab to din nahin, raat ho gaya! Mein beti se bola, mera haath se gadi to theek ho sakta hain, tumhara takleef theek nahn ho sakta.” Nasser Khan, the stocky garage owner, speaks movingly of his daughter’s tryst with cancer.

The tumour returned to rob Ayesha of her smile and hair yet again in 2012. The girl would have to undergo 12 more rounds of chemo, yet another surgery followed by radiation.

“I will send her back to India to study – wooh difficult back home. When Ayesha grows up, I didn’t have to run from one place to the other for my therapies,” says Ayesha.

“Many of my countrymen have gone to other hospitals in Delhi where doctors and interpreters split ‘commission charges’ from patients like us. But RGCI mein saaf likha rehta hai. Also, this entire hospital is dedicated to cancer treatment while other hospitals have one oncology department and only a few doctors. Cancer treatment is very difficult back home. When Ayesha grows up, I will send her back to India to study – wooh cancer ki mechanic bhar kar lautegi!”

It is to the sweetness of such a hand that a father returns time and again from Kabul for the treatment of his daughter Ayesha. “Bahut meetha khaya yahan, kabhi thoda kadva mile to kya, use bhi hazam kar lenge,” Nasser Bhai says disarmingly about his mostly sweet and occasional sour experiences at the institute. Yet, he is one of the many who return to RGCI, not in the least because of what’s euphemistically called medical tourism.
We are trying to integrate our IT system so that all processes are online. “What isn’t ‘off-line’ is that the patients are treated as human beings and not a business proposition. They come by word of mouth – and irrespective of whether they are from Afghanistan, Africa or India, they are served and charged without discrimination. He knows “such differential is not part of the work ethic of RGCI.”

To trounce a ferocious enemy such as cancer, however, the battle-makers must constantly ascertain new strategies. The hunger to know more, to do better, to somehow seize this emperor of all maladies has to be part of the work ethic of a cancer institute and its people. The hospital is already in talks with MD Anderson Hospital, USA, whose team has been to RGCI as part of developing a Sister Institutional Network. The objective is to facilitate training from the best men in the industry and exchange information.

“RGCI is the finest among hospitals in Delhi and Bombay,” says GC member Jyotsna Govil. “I don’t know what to compare RGCI to.

Technologically, we are up there with the best anywhere. Yes, it is 17 years old and a lot has changed. We have a long way to go to build newer facilities, provide the working ambience that our doctors and nurses richly deserve. I want much better for them. What we will build now will be a generation ahead. But if I look at what RGCI can be today – I wouldn’t want it to be a 5-star hotel. I’d much rather have a kind doctor, good nursing and caring set-up. I saw this piece of news headlined – Cyberknife Treats Cancer in a Day. RGCI doesn’t make such claims and I hope we never do. At one of our conferences, the Vice-President of India said RGCI is known through its work, not headlines. That, for us, is the greatest compliment.”
The chief pathologist was peering down his lens at a specimen of the supraclavicular node in the neck region. In another timeline, his colleague was gazing at a gastric biopsy. It was routine to rotate duties – from cytology and histopathology to immuno-histochemistry – to avoid intellectual fatigue. The chief pathologist reported positive for Non-Hodgkin’s Lymphoma. His colleague reported the sample positive for cancer of the stomach. This was bizarre. How could the same person house two different cancers? The clinician who saw the reports was stunned.

The chief pathologist reported lymphoma without being aware that the gastric cancer had already been identified – his colleague hadn’t yet written and finalised his report. The same cancer should have normally travelled to the node or perhaps, the node was reacting to something else. If this was a mistake – it was a serious one. The grim clinician brought it up for review at the Tumour Board. The pathologist’s instinct told him he wasn’t far from the truth. But the lymph node disease was a lot more complex than the gastric cancer biopsy. He didn’t want to take a chance. A second opinion was in order. The hospital gave its nod and bore the cost. In the rarest of the rare cases, the report confirmed there were indeed two primary cancers in the same person at the same time.

“There cannot be any dogma in biology – it is no one’s monopoly,” says HOD Pathology Dr. Anurag Mehta. “Why do two separate cancers occur in the same person at the same time? What is going on in the body to encourage two parallel cancers? Cancer cells have their own ways, different from other cells, with unusual attributes. They acquire the ability to move around. How much and how rapidly they will travel, how much energy they will take away from their origin, how they will violate their new settlements… there are too many variables here. Cancer biology is only partly predictable as of now and being dogmatic here is inviting trouble.”

When men and women, surrounded by the familiar microscopic world of the dead put aside their certainty and insecurity, they love something greater than themselves. It points to their commitment to the “magnified real world of patients and illnesses”. RGCI has spawned a culture where people ask for another opinion when they are unsure. Their intent is – if we cannot get it right, then let someone else get it right because at stake is a life. The management stands by its pathologist knowing it to be a true quandary. Similarly, 18 per cent of the total cases come as referrals from other hospitals in Delhi and states like Punjab where ancillary support, like immuno-histochemistry needed to crystallise opinion, is absent. RGCI renders second opinion on demand. Fortunately, that culture hasn’t become sterile 16 years after the department was founded.

Technology Supervisor Meenu Bhatia recalls fondly the founder head of pathology Dr. RN Verma. “Unke naam se hi log yahan aate the... people counted on Dr Verma so much that they would bring their samples from outside to him. Many of our samples – FNAC slides, blocks, bio-chemistry testers – came from nearby hospitals and people whom we were not treating at RGCI. Often, he would go collecting samples to process and report them here. We did blood tests – cancer markers – to
Accuracy and precision become the markers for the lab’s effectiveness. Being as close in diagnosis to the biological variable and possessing the ability to reproduce approximating results in repeat tests of the same sample affix the stamp of quality to it. The disease causes changes in the body that lead to biochemical alterations, says the pathologist. “Is my measuring of these alterations a true reflection of the severity of the process? How close is my report in terms of the numerical value of that alteration? That is accuracy, which is otherwise immeasurable. We work and therefore err on the rare occasion. But we strive to minimise the errors by following strict regimes of inter-lab comparisons and participating in testing on external specimens. We have some of the best standards to measure ourselves against set by the WHO or agencies like AIIMS; CMC, Vellore; the Indian Association of Medical Micro-biologists; Bio-Rad; Royal College of Pathology, Australia; that do proficiency testing.”

The pathologist charts a cancer patient’s journey through plotting cells and tissues. In his anonymity he is also remote, rarely touching or treating a living person. The patient is usually just a sample number. But the patient depends utterly on the pathologist’s verdict – his skill and understanding – before he can take his first step in treatment. The patient is unaware of the processes that go into making an accurate and precise report. But it is this nervous step that the pathologist at RGCI constantly draws to mind when he reports his verdict.

“We can neither risk under-diagnosis nor over-diagnosis in a cancer institute. The former deprives the patient of rightful treatment and the latter can lead to a mutilating surgery or remedy that has serious side effects, both in short and long terms,” cautions Dr Mehta. This fine aspiration for balance in the RGCI pathologist drives his pursuit for efficient, effective and equitable patient care.

The lab is equipped to provide complete diagnostic services, including molecular testing to identify precision medicine. The lab’s immuno-histo chemistry service – used to determine the source and stage of cancer – provides a panel of investigations comparable with the best anywhere. Bio-chemistry, microbiology or hematology – the turnaround time is two hours. Histo-pathology, which includes biopsies and FNACs, needs 18-48 hours before reporting by virtue of being labour-intensive and prone to a greater possibility of error.

Adhering to the multi-modality practise of the institute, the laboratory not only offers virtually the entire spectrum of investigations necessary for a cancer patient, most tests are done in-house, including for molecular biology, immuno-histo chemistry, microbiology and bio-chemistry. That facilitates stringent quality controls in the pre-analytic phase which is likely to be lost in processes such as storing, transporting and pre-analysis time in the event of outsourcing.

The focus is always the patient. Therefore, we emphasise intimating the outcome of tests to the patient as early as possible without compromising on quality and due diligence. Procedures like biopsies and FNACs have a relatively longer turnaround time. There is a perception that even a day’s delay will cause the cancer to spread. That may not always be true but we understand the patient’s anxiety who wants to start treatment quickly. We are answerable to our clinicians as well. We try and match up to their expectations.

Dr Anurag Mehta
Dr Mehta, who introduced quality assurance in anatomic pathology by defining robust quality indicators, led the pathology team to achieve NABL accreditation. Carrying forward a legacy of transparency and rigour, the chief pathologist has maximised automation to make it a state-of-the-art diagnostic centre.

Cancer marker tests which once took a whole day to report are now done in a couple of hours permitting outstation patients of the hospital to take the necessary next steps and return home the same day. Rapid techniques have allowed sensitivity tests to be done in a matter of hours instead of days. One such test is for the highly toxic Methotrexate level which can induce remission in children with ALL – a kind of blood cancer. “A body with cancer becomes vulnerable to all kinds of infections and disease. We have added to our palette, investigations for our immuno-compromised patients to test for germs, fungal infections and sensitivity. NS1 antigen test, for instance, allows rapid detection of dengue on the very first day of the fever even though the antibodies may appear several days later,” says the technology supervisor.

As one of the five hospitals in the country to do NAT testing for blood, the lab is redefining haemo-vigilance, or safety in blood screening. The tech-intensive test costs 900 rupees for all patients. “Near-zero risk blood isn't meant only for those who can afford it. It militates against my idea of equity. For the last year and a half, we have been doing NAT testing to minimise, if not eliminate, viral infections transmitted by blood transfusion. Of the 18000 samples we have tested in this time, nine have tested extra positive. It means we have been able to save with NAT screening 27 people (since blood can be divided into three components of RBCs, platelets and plasma) from infected blood.”

Vigilance, effectiveness, precision, accuracy and the like make for a trustworthy lab. Beyond the verbal miasma, most patients respond to its 'sensitivity'. Their 'feeling' about the lab is perhaps only as nebulous as the accuracy in a path report! It matters to them whether the lab gives reports swiftly. “Our interaction with patients is little, particularly now that we have fully automated systems. But here is a patient from Aligarh who is anxious to get his PSA report. Normally, we require at least two hours before we can hand him the report. I have to either convince him to wait if he is in a hurry or try and comply with his demand without compromising on quality. Whatever I do, those 15 minutes of reassuring him make my day worthwhile,” says Meenu Bhatia.

It matters also if the hospital goes beyond hubris and gives the patient a chance to consult another lab. “We encourage our patients to take their blocks and slides and seek a second opinion. We charge nothing for the blocks and a nominal amount for the slides. We may have made a mistake in one case out of 1000. But not a single patient has suffered on that count or received incorrect treatment,” says Dr Mehta.

In a landmark step towards offering advanced cancer detection technology to its patients, RGCI has tied up with the Yale School of Medicine to conduct molecular tumour profiling (TP). The high cost of the test is offset by the fact that the information from this investigation delivers high-quality, personalised precision medicine to the patient. Precision medicine tailors medical treatment to the genetic characteristics of each patient’s tumour.

Some of the best pathologists at the Yale School analyse the DNA of a patient’s tumour and provide the report within a week to 10 days. RGCI oncologists can then match the genomic profile of each patient’s tumour to available drugs or drugs in clinical trials. This personalised or targeted therapy can enable many more patients to receive only those drugs that are known to work specifically for their kind of cancer.

With the availability of this technology, RGCI becomes the first cancer hospital in India to offer such a facility to its patients. But more importantly, targeted therapy for a mutated gene reduces the need for chemotherapy widely associated with extreme side effects.

Did the lab test correctly? Pathology identifies the target – point of focus – for precision medicine. So a patient with HER2 breast cancer gets only Herceptin. Tested positive for EGFR growth factors in the lung, the patient gets drugs that inhibit EGFR growth. So with KRAS testing that gives negative predictors for colon cancer treatment. “We could have done and offered a lot more. For example, we could test for all possible targets in a cancer type and inform the clinicians so they can intervene with some targeted drugs. It will take us time to get there. But whatever we are doing right now is unambiguous and systematised. We are able to indentify our own targets in-house, check for quality and allow for the practise of precision medicine. My physician can come back to me and tell me a certain drug isn’t working. Unlike the faceless diagnostic centre, here it is my neck on the block. And I am happy that way,” Dr Mehta smiles.

He has reason to. His lab tests positive on critical counts. And for once there is neither a disease there nor its pathology.
Tumour Board

The Growth of Symphony

“A 50-year-old woman was diagnosed in November 2012 as having locally advanced breast cancer. A PET scan was done for staging which revealed the presence of cancer in the left breast, supraclavicular and internal mammary lymph nodes. The patient was given the options of surgery or radiation followed by change of chemo. However, the patient took a second opinion from an eminent oncologist elsewhere. He advised change in chemotherapy.

The patient, subsequently, received 3 cycles of new chemo, post which a PET scan was done. It showed complete metabolic response in the breast lesion and supraclavicular lymph nodes. The patient sought a second opinion with the same Mumbai oncologist who now advised RT followed by chemo.

The questions before the tumour board – the patient clearly has an aggressive disease. However, the disease is still loco-regionally confined. What should be the next modality of treatment?

a) surgery followed by RT
b) RT only
c) Continue chemo

The patient’s case above as read out by the treating consultant (TC) at a Tumour Board meeting

Dr A: I think we should be clear in our thought process about what is the intent of treatment before we proceed?

TC: Although the biology of the disease is aggressive, it is still loco-regionally confined. Hence, the intent is curative.

Dr B: Are the supraclavicular lymph nodes still felt? Is it a metabolic / morphological response?

TC - In what way will it alter the treatment plan?

Dr B: Sometimes, even after the metabolic response on PET CT, the patient can still have the presence of cancer. Hence, it is important to know whether it’s a morphological or metabolic response.

TC: It is both metabolic and morphological.

Dr C: In view of the aggressive biology of the disease, I propose RT to the breast and supraclavicular region.

Dr D: But wouldn’t that change the intent from curative to palliative? In my opinion the patient should be offered surgery followed by RT followed by chemo since there is a 20 per cent chance to cure the patient.

TC: I agree. The first principle of oncology is Cure When You Can. Although this patient has received 2 lines of chemotherapy, her disease is still loco-regionally confined. Surgery followed by RT and chemo will give her the best chance of cure.

Alright then, we agree that we should be aggressive in the management of the patient and give her the best chance to combat this deadly disease.”

The language of clinicians may be technical and tough to comprehend. But the meaning breaks the wordy barrier and shines forth distinctly in the minutes of this Tumour Board meeting. It is to “give the patient best chance to combat this disease and of cure.” The case was brought to the Tumour Board by a consultant medical oncologist who, in the best interest of the patient, advised the latter a different modality of treatment. The consultants discussed the case openly, pulled out instantly...
participate in the Board so they were also part of the solution, not merely the problem. “Apart from transparency, the inclusion of patients was a confidence-building measure. It is very unusual for cancer centres to invite patients to Tumour Board meetings. The IRCH and AIIMS were, perhaps, the only ones who did. Dr Pandey would ask patients to bring in their X-rays, scans and records. Anyone in the Board – from medical, surgical or radiation – could examine the patient or see the images. The radiologist was asked to give an opinion on the images. The treatment and its sequence were decided there and then. The decision on second line of treatment in the event of the patient not responding was made... this was multi-modality treatment in every sense of the word.”

Over a period of time, the Tumour Board became the gold standard for transparency at RGCI. A day in the life of the institute was incomplete without a Board meeting – and continues to be. A small room in the Radiology department – a 25-seater ECG area – witnessed the early meetings. A year and a half later, the venue shifted to the second floor opposite the library which could house about 80-90 people. In 2010, what was called the ‘Sheesh Mahal’ on the first floor of the administrative block hosted the meetings. It was converted to Day Care a year later and since 2012, the IGRT waiting area has been the setting for some riveting Tumour Board meetings.

“The onus to bring a case to the Board is on the doctor,” explains Director of Radiology Dr AK Chaturvedi. “Oncology is a very interesting speciality – it inherently needs multi-modality. A doctor may continue to treat the patient on his own for some time. But some day it will be necessary for the patient to be seen by another speciality. If he is trying to hide something, the cat will be out of the bag sooner or later. So everyone is wise enough to discuss upfront the tough areas and open themselves up to genuine criticism. It happens very often and that helps the system to grow. I wouldn’t say it is fear but a matter of ethical practice, wisdom and integrity. And if there is a little bit of fear, so be it,” he says.

The NCCN guidelines 2013 for consultation and the second opinion was honoured. The patient was initially suggested only radiotherapy which would have been for palliation. Subsequent to the Tumour Board discussion, the patient was offered surgery followed by radiotherapy and chemo, thereby offering her a chance for cure.

It isn’t a one-off occurrence though. Case histories presented and decided upon at tumour board meetings underscore the spirit of RGCI – the patient is of paramount importance. The Tumour Board lends validation to that spirit and to the practice of multi-modality treatment at the institute.

The term – Tumour Board – has a ring about it. It inspires knowledge, experience, awe, clarity, confidence, decisiveness and brotherhood. It is a group of clinicians from all clinical and diagnostic modalities who confer on treatment and outcome options for patients with tumour. They come together to check the individual oncologist’s feudalism and balance it for what’s best for the patient.

“We had the Tumour Board from day one when we opened in July 1996. We met twice a week where all consultants and residents sat between 3 and 4 pm to discuss difficult cases. Every now and then, we would come to verbal blows even. But after that we were brothers, good boys again,” laughs Dr Dewan. “Everyone truly contributed. Dr KK Pandey chaired what were robust clinical discussions. It was bonding time for us as well but we talked of why taking decisions were more important than making incisions.”

A classic Tumour Board day started – as it still does – with a clinician explaining a case and the reasons for bringing it to the Board. Was it a diagnostic or treatment problem, treatment failure, or insistence of the family that they wanted a second opinion from the Board? If the problem pertained to medical oncology, the chair – Dr Pandey then – would direct the questions at Dr Doval. He encouraged patients and their family to participate in the Board so they were also part of the solution, not merely the problem. “Apart from transparency, the inclusion of patients was a confidence-building measure. It is very unusual for cancer centres to invite patients to Tumour Board meetings. The IRCH and AIIMS were, perhaps, the only ones who did. Dr Pandey would ask patients to bring in their X-rays, scans and records. Anyone in the Board – from medical, surgical or radiation – could examine the patient or see the images. The radiologist was asked to give an opinion on the images. The treatment and its sequence were decided there and then. The decision on second line of treatment in the event of the patient not responding was made... this was multi-modality treatment in every sense of the word.”
The Board is the executive to the multi-modality parliament. Many minds together instead of one improve the outcome for the patient. This is further backed by international guidelines or the National Comprehensive Cancer Network, NCCN, held up as evidence. The upshot of such medical democratisation is that needless treatment is avoided. If evidence supports terminating treatment, the Board may decide in favour of Best Supportive Care. No more chemo, no radiation, no more poison, no more trying to cure – just loving concern and care. The Tumour Board takes a couple of such decisions almost every day to avoid unnecessary spending and distress to the patient’s family.

“All of us take some risk all the time where advantages far outweigh the disadvantages,” reminds Dr Chaturvedi. “It is important to know more about the disease. At times, an investigation or a biopsy may not be necessary if it is not going to radically change the course of treatment. But we allow ourselves to be converted in the light of new knowledge.”

The ability to convert indicates a generosity of spirit and constant willingness to learn. It has also helped the institute to keep abreast of the best patient-centric practices in oncology worldwide. RGCI has come a long way from developing its own protocols at a time when there were none in India, or elsewhere in the world, to following the NCCN guidelines. These guidelines leave enough room for interpretation and individual genius within the larger framework for cancer practitioners as reflected in the RGCI Tumour Board.

Senior oncologists are driving the next generation of doctors – residents and DNB students – to attend the Board meetings by awarding the best presentation or discussion. The number of man hours spent on Tumour Board meetings has gone up from 4000 to 10,000 per year owing mainly to the rising number of patients but also because these meetings have spawned the futuristic concept of Multi-Speciality Clinics. Like the Board, the MSCs are held three days of the week. While the former takes up general cases, the MSC focuses on specific organs each day. For example, days for breast, head and neck, leukemia and others are fixed in MSCs even as the principal remains the same as that of the Tumour Board. The practice is unique to RGCI in the country and heralds the formation of Centres of Excellence in the next few years. The centres are envisioned as organ-specific hubs that will house all services – OPD, ward, supportive, preventive and investigative – in the same wing to facilitate patient care.

Establishing protocols, finding out the best interest of the patient and executing it is fundamental to the Tumour Board. When he hears multiple people speak in multiple, even conflicting, voices, he is confused and afraid. The Board addresses precisely this fear and confusion. It gives him the confidence that he isn’t another case that is staged and played out in an onco-theatre. There is someone out there deeply interested in seeing that he gets the best that life affords him.

The best patient-centric practices in oncology has also helped the institute to keep abreast of spirit and constant willingness to learn. It is them together even though the former is the grand old man of cancer, he was senior to admit to a mistake or complication that occurred during surgery. A person must have clarity, gravity and dignity, he said. His foremost concern when a patient came to him was - what is the best I can do for him? “No one’s perfect but remember, you give your utmost,” he cautioned. And Tumour Boards at RGCI reflect the pursuit of excellence that he inculcated in his colleagues.

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Formerly with the Safdarjung Hospital, Dr Pandey was the first to spearhead the concept of Tumour Board in the private sector at RGCI. He chaired the board before Dr Doval took over in 2007. The coordinator or convener was selected by rotation. As the grand old man of cancer, he was senior enough to give anyone a dressing down and still be vastly respected. “People were scared of him,” laughs Dr Dewan, “always on the tenterhooks as to their mistakes.” He insisted on Tumour Board cases to be reported systematically – slides prepared, power point presentations made and short notes written about the patients under discussion before 12 noon so that the paper could be circulated to everyone. However, some of the practices declined when he left the hospital in 2007.

What remained undiminished was the aspiration to keep the delicate balance between eminence and evidence. The new crop of clinicians cites books and literature as evidence. Dr Pandey would playfully tweak the intellectual ear of the younger lot with ‘degrees don’t make a man, experience does’.

“Whenever a doctor would say ‘but this is written in the book’, I would tell him, ‘I am the book. Try to read me,’” says an amused Dr Pandey. “You do a surgery and your mortality rate is 20 per cent. The same surgery in another institution is done with 5 per cent mortality. Doesn’t this become evidence against the former institution of something not being right there – perhaps the doctor must get more training and improve his skills,” says the man who has been a leading light in surgical oncology. “A surgeon who has the least morbidity and mortality becomes evidence for others.”

Like he has for many of his successors. You’ve got to see it as a measure of his confidence, smiles his student, reiterating that it is not about evidence versus eminence. It is them together even though the former is a significant change from the old order. And it is in men like Dr Pandey that the two apparent opposites find resolution. He was – is – that book, like the teacher who is the teaching.

The Board is the executive to the multi-modality parliament. Many minds together instead of one improve the outcome for the patient. This is further backed by international guidelines or the National Comprehensive Cancer Network, NCCN, held up as evidence. The upshot of such medical democratisation is that needless treatment is avoided. If evidence supports terminating treatment, the Board may decide in favour of Best Supportive Care. No more chemo, no radiation, no more poison, no more trying to cure – just loving concern and care. The Tumour Board takes a couple of such decisions almost every day to avoid unnecessary spending and distress to the patient’s family.

“All of us take some risk all the time where advantages far outweigh the disadvantages,” reminds Dr Chaturvedi. “It is important to know more about the disease. At times, an investigation or a biopsy may not be necessary if it is not going to radically change the course of treatment. But we allow ourselves to be converted in the light of new knowledge.”

The ability to convert indicates a generosity of spirit and constant willingness to learn. It has also helped the institute to keep abreast of the best patient-centric practices in oncology
"My heart aches and a drowsy numbness pains
My sense, as though of hemlock I had drunk
Or emptied some dull opiate to the drains…"

Indu Bala Arora’s voice drops a little as she begins to reel off ‘Ode to a Nightingale’ from memory that seems to have become more acute with time. The poet isn’t the only one who explores transience in the poem. The 66-year-old woman who recounts it nearly two centuries later has had her brush with mortality – several times.

The first time was around 2002 when she knew she was a prospective candidate for breast cancer from a change in the nipple of a breast. Dr AK Dewan broke the news to her. “I knew it in my gut… but a surgery is still a shocking piece of news. That shock was cushioned by my doctor. Dr Dewan is an amiable man, he makes things easy. Always smiling, he even makes a mastectomy appear as simple as looking for a nail polish, as commonplace as brushing your teeth."

Dr Dewan, one of the first surgeons to have joined RGCI and, now, one of the senior men at the hospital, swears by some arguably old-fashioned practices in oncology. “I have always held that the hand scan is more important than the CT scan. A doctor should examine the patient not merely for good diagnosis. A patient, especially one with cancer, feels like a pariah. She needs to be comforted, both physically and psychologically. The hand scan is, literally, the beginning of the human touch, the healing touch. Placing your finger on the wrist is not to merely listen to the pulse. It is to divine the panic pounding against a patient’s heart. It is to let her know she will be made well in all possible ways.”

By and large, senior oncologists at the hospital adhere to this practice. Younger doctors, however, fancy blood tests, X-rays, MRIs and CT scans, says the surgeon but “we teach and preach continuously it to our Residents and DNB students: people don’t care about how much you know, they care about how much you care. And I know from experience, half their suffering is gone when they feel they have been examined properly.”

Dr Dewan’s mentor, a distinguished surgeon and the man who founded surgical oncology at RGCI, Dr KK Pandey, remembers fondly his student as sincere and dedicated. “To know that Dr Dewan was part of my team was to be certain that a patient I had operated upon would be well taken care of irrespective of whether it was day or night.”

Indu Bala, a former Delhi University lecturer, knew instinctively she was in good hands. This was a place where most doctors were solicitous, and took care of their patients by caring for them. This was also unlike other hospitals that only had cancer wings. RGCI had eight years ago decided to go into sub-speciality within surgical oncology.

Oncologists such as Dr Pandey, Dr Dewan, Dr Sudhir Rawal, Dr Kapil Kumar and others in the team were trained in more than one stream of surgery. But the department was split into seven sub-specialties: Head and Neck, Breast and Thoracic, Orthopedic, Uro-Gynaec, Gastro-Intestinal, Neuro and Reconstructive Services.

“Most surgeons perceive it to be risky business to stick with one surgery-type. The prevailing notion that a surgeon must be able to do multiple or all kinds of surgery could come from a fear-mindset – from the apprehension of being confined to a speciality and in the process lose out on the patients,” says Dr Dewan. “But this mindset may stand in the way of developing clinical acumen and surgical skill. Doing a head and neck, thoracic, GI or any other surgery day in and day out was our definite route to improving individual expertise. But in the process, we also procured the best equipment, technology, manpower and achieved better results. Fact is if a surgical oncologist operated upon everything, a cancer hospital wouldn’t have specialised services such as robotic, reconstructive and laser surgeries.”
In the past, we were high-touch and low-tech. Now increasingly, we are moving towards high-tech and low-touch. The need of the hour is to be high-tech with high-touch.

Dr AK Dewan

“The Department of Surgery is evolving in RGCI and our effort is to charter its path on the lines of Sloan Kettering or MD Anderson,” says Dr Sudhir Rawal, Director of Surgical Oncology and Chief of Uro-Gynaec Surgical Oncology. Breast, Thoracic and Soft Tissue are on their way to becoming three different specialities as are Uro and Gynaec given that RGCI is home to some fine surgeons in the trade. Opinions have been sharply divided, for example, on whether Uro Oncology is worth being a sub-specialty even though it has existed in RGCI since its inception in 1996 but is breaking new ground rapidly.

“I agree there are borderline surgeries. An average surgeon, fearing he will make the patient worse, may opt for radiation instead. Normally a prostate cancer patient is recommended for surgery if the PSA is below 20. But surgeons in Belgium and the USA have successfully operated on patients with PSA as high as 600. I have performed similar surgeries with PSA of over 200. We are talking of highly experienced surgeons who have done the same things day after day for years on end. But if you want to do stone and stenosis in the urethra (narrowing of urethra) and pyelo-plasty (relieving the blockage of the kidney where it joins the ureter) and you also want to excel in such a surgery, it is not going to happen,” concludes Dr Rawal.

The big plus of sub-specialities is the institutionalisation of good protocols, says Dr Kapil Kumar who heads the breast and thoracic unit. “Sheer volumes and specialisation within a service allows for rigorous interpretation and execution of protocols at RGCI. The workflow is already established and I don’t have to tell the next doctor in my department what to do. That apart, the ‘kind’ of breast surgery I did in the eighties or even nineties is not the same as the one I do now. We could not, for example, do breast conservation till about 1992. We had to remove the entire breast even when the cancer was stage one or two. Consequent to high volumes, we went in for sub-specialisation. While other city hospitals may be doing 100-odd breast surgeries per year, we do six times more. Now I can do more in the same area. I can offer my patient conservation and reconstruction. A high-volume centre like ours is very likely to have less morbidity in esophageal cancers for instance because we do 50-60 such cases whereas our peers elsewhere in the city do just a handful.”

Today, the faculty of Surgical Oncology consists of several senior consultants, consultants, clinical assistants in addition to residents and DNB students in various sub-specialities. The department is equipped with eight major operation theatres, three minor theatres, 28-bed post-op ward and intra-operative and post-op monitoring facilities round the clock. In a unique first in India, the Department of Genito-urinary Oncology has added to its armamentarium High Intensity Focussed Ultrasound (HIFU) for treating prostate cancer with good results and virtually zero morbidity.

RGCI is a rare oncology centre with sub-specialities within a speciality service. On lines similar to surgical oncology, radiation and medical oncology services are also divided into sub-specialities. Medical oncology has Leukemia and Lymphoma, Paediatric Haemato-oncology, Breast and Thoracic units. Radiation oncology has separate units for Head, Neck and Brain, Gastro-Intestinal, Genito-Urinary and so on.

However, in what may seem to be an apparent contradiction, Dr Pandey says, a super specialist may be very sure of his domain. But he is also limited by the same speciality that makes him an expert. “The surgeon of yore was trained to look after every compartment of the body. He could deal with a tumour in the kidney as well as he could open the chest, the abdomen and take care of them plus protect the big vessels. If he found a liver tumour that he couldn’t operate in a particular hospital, either because it was too large or because it needed simply to be transplanted, he needed to accept it and refer the patient elsewhere. That’s what separates a good doctor from the average one.”

The founding fathers of this hospital and administrators like Dr Yogi Mehrotra were clear about one thing – always put self in the shoes of the patient before taking a decision, and do what is best for him. If a brain tumour can be dealt with the Gamma Knife or Cyber Knife and does not need the more invasive open surgery, I will tell the patient if I don’t have these less-invasive procedures and, if asked, even suggest some places where he can go for treatment. Many of our doctors have done this a number of times for various reasons. The upshot is our patients return to us for cancer treatment,” says Dr Dewan contentedly, now the Medical Director of RGCI.

In a sense, the division within a speciality is only a replication of the clear apportioning of cancer services into surgical, medical and
A patient with metastasis in the liver
came to me. He had pain in the
abdomen. I heard his story after
which I made a clinical examination,” recounts
Dr AK Dewan who maintains that the hand
scan is more important than the CAT scan. The
Medical Director of the hospital and Chief of
Head and Neck Surgical Oncology belongs to a
vanishing breed of doctors who believe patients –
especially of cancer – must be examined not only
for good diagnosis but also for their emotional
well being, that they feel comforted. “I would
like to meet your family,” the surgeon told the
patient. The patient was elderly, alone, unlettered
and appeared to be a man of meagre means.

“Why talk to them? Tell me – I can take it. They
have been telling me about liver cancer for the
last 14 years,” he said. The average life span of
people with secondaries in the liver was months,
not years. The oncologist was more than a little
surprised. He asked for proof. The man brought
out laminated prescriptions of the Safdarjung
Hospital dated July 1988. ‘Metastatic Carcinoma
Liver’, it read, prognosis in brackets said
‘3 months’ duly signed by the doctor. A second
biopsy at Rohtak Medical College had confirmed
the diagnosis.

Could he identify the doctor who had signed that
paper, Dr Dewan asked the patient. The man
shook his head. “Those were my signatures! I
knew you the enemy and know yourself you need not fear
the results of a hundred battles. A hundred
battles down, the cancer community of
scientists, doctors and researchers are no
longer stunned by the ambush of an obscure
enemy. They comprehend it a lot more, a
lot better. Worldwide, the unimodal war
has mutated into multi-modal treatment. It
combines all three main therapies or a
combination of two to relieve symptoms and
pain besides making possible a longer disease-
free life, or remission.

RGCI led this shift from ‘my patient’ to ‘our
patient’ where more than three-fourths of
the patients come with advanced cancers and
need adjuvant or multi-modal therapy in case
of solid tumours. Only certain kinds of cancer
such as leukemia, lymphoma, myeloma,
plasmacytoma are essentially treated by
medical oncologists. “Cancer care needs
comprehensive care – surgery, radiation
and medicine, else we don’t do justice to our
patient. Today we, as a multi-modal centre,
are second only to Tata Memorial in Mumbai,”
says CEO DS Negi.

The concept or understanding of cancer
biology was virtually non-existent at one
time. Now, a 35-year-old patient for breast
cancer is likely to need radiation after surgery
if there are nodes in the armpits. She will
definitely need chemo and may need hormone
treatment even if it is a 2cm tumour.

Two weeks after the surgery, then, Indu
Bala’s surgeon sent her for chemotherapy
radiation with the founding of RGCI. It was
the first time that a dedicated cancer hospital
had envisioned cancer therapy as a multi-
modal treatment in North India where all the
three services were accessible under the same
roof. The principal of having sub-speciality
departments within the three main oncology
services is similar – the patient in RGCI has
access to all types of therapies, particularly
surgical, for most kinds of cancer under the
same roof as well.

Ancient Chinese military strategist and
philosopher Sun Tzu said if you know the
enemy and know yourself you need not fear
the results of a hundred battles. A hundred
battles down, the cancer community of
scientists, doctors and researchers are no
longer stunned by the ambush of an obscure
enemy. They comprehend it a lot more, a
lot better. Worldwide, the unimodal war
has mutated into multi-modal treatment. It
combines all three main therapies or a
combination of two to relieve symptoms and
pain besides making possible a longer disease-
free life, or remission.

As she battles a fifth recurrence of cancer –
she had a triple negative breast cancer that
started off in the breast has now
migrated to the bones. She cannot bend
her knee nor can she undergo replacement
because of the bone cancer. Dr Dewan
has told her further surgery would not be
successful. He is no longer her primary
clinician, but she stays in touch with him.
“I speak to him any time I have doubts – and
I have never been disappointed,” says Indu
Bala who now volunteers for Cancer Sahyog,
a unit of the Indian Cancer Society and an
emotional support group for those touched
by cancer.

Keats is still her beloved poet. But unlike
his nightingale who seeks immortality
through her song, Indu Bala has moved to
understanding life through the butterflies
she paints – locating the beauty of existence
in its very transience.

Multi-modality, you see, applies as much to
the cure as it does to the disease.
Kausalya (name changed) came to RGCI in 2003-04 with lung cancer. After three cycles of chemotherapy in first line treatment, her doctors found that her blood counts were low and she contracted fever. Clearly, standard chemotherapy was not working for her. Luckily, the hospital, then, was one of the sites for the trial of a new drug for lung cancer. Life was hanging by a delicate thread. Like many other patients who know that all doors to cure had been closed, Kausalya knew she had but a small window to look out from for a breath of fresh air. A targeted drug for her lung cancer – an oral pill – was being tested in the hospital. Given the dismal survival rates in lung cancer, clinical trials are of great consequence to find new ways of treating the disease. “We told her of the clinical trial and she gladly agreed to be part of it,” says Dr Dinesh Chandra Doval, Director of Research.

Dr Doval founded the research centre at RGCI in 1997-98. A vastly experienced medical oncologist, he has steered the hospital’s participation in 70-80 national and international studies in areas of predominantly breast, kidney, and lung cancers. He established a team of study coordinators who were trained in clinical trials. Subsequently, trained research coordinators entered multi-national and pharmaceutical companies as well. Along with other co-investigators and Principal Investigators, he conducted landmark studies in breast and lung cancers.

RGCI became the first centre to find out and publish the combination regime for cancer of the gall bladder that became the standard of care worldwide. The centre participated in a study that was testing for a drug called Taxol in its nano form for mostly breast and ovarian cancers. This new version had significantly fewer side effects and was a far improved version of its predecessor. The institute broke new ground on how an orally active drug – Lapatinib – directed at a kind of breast cancer could be integrated into the combination regime.

The hospital was chosen as the site for a study to show how addition of Herceptin, a targeted drug, to chemotherapy was far more effective in early breast cancer of an aggressive type known as Her-2-neu. Women who were so treated had better survival rates than those who did not get Herceptin.
The centre helped develop Iressa, a drug inhibiting an overactive receptor that causes cancer cells in the lungs to multiply uncontrollably. The study showed the drug could work up to 60 per cent if this lung receptor was mutated. Two out of the four or five latest drugs for kidney cancers were also developed as part of the trial studies conducted at the institute.

A robust, rigorous clinical trial is about the significant experience of its executors. It is about holding fast to the best ethical and regulatory practices followed all over the onco-world before research gets anywhere near a patient. Collective work, informed consent of the patient and mandatory compensation to protect patient volunteers – clinical research is about all of these. But a trial becomes truly worthy by virtue of the spirit in which it is carried out – the spirit that transcends the letter of directives given by ethics boards and medical councils.

“RGCI has participated in about 150 trials. Of these, Dr Doval has done more than 85. Apart from the decades of experience and thorough knowledge of the subject, he is known as an extremely aggressive Principal Investigator (PI) in the trial fraternity. He remembers his patients and supports them. PIs can be casual and pass on a lot of their responsibility to coordinators. Dr Doval is a hands-on PI. He checks the work of the coordinators every day which is by itself an enormous task. As coordinators, we are expected to file summary reports of each of the patients in trial. He not only observes on site but reviews the reports and signs them,” says Dr Shruti Grover, Lead Research Coordinator.

The centre compares with Tata Memorial in terms of sheer numbers who sign up for a trial. Its work as a specialised oncology facility in the last decade and a half has made it the chosen site for contract research. The institute has bucked the trend of a drastic fall in clinical trials after organisations. The institute has bucked the trend of a drastic fall in clinical trials after

18 ongoing studies while Dr Sudhir Rawal, Dr AN Jena (formerly with RGCI), Dr Bhurani and Dr Sunil Gupta have been conducting trials in their respective oncology areas.

But a centre owes its listing and continuous success not merely to individuals. A whole team of facilities and facilitators comprising specialised multi-modal therapy, diagnostics and laboratory, coordinators and nurses play a vital role in making for a vibrant research site.

“At RGCI, we talk to the patient, we listen to him. We remind him that he has to come for a test, treatment or evaluation. We tell him to take his standard pre-chemo medication and call us if he has any problems. We suggest he goes to the nearest doctor for the necessary tests and bring or send the reports to us. We try and save his time by collecting his reports for him and filing them for him while he waits in the OPD,” says Dr Grover. “Unlike some other research sites, we go by the guidelines issued by the Institutional Review Board and ICH (International Conference on Harmonization of Technical Requirements of Pharmaceuticals for Human Use), which is our Bible. We explain the details of the trials to our patients. When they sign the consent form, we tell them they will be taken off the trial after the standard period of about two drug cycles if we find they are not benefitting from it.”

The nearly cent percent clean slate of the centre’s work obliges a rethink on the way trials are perceived as risky or self-seeking. “RGCI has done trials in breast cancer for early, metastatic and patients who have failed standard chemo in metastatic cancers,” says Dr Grover. “A trial protocol can improve and prolong the quality of life. Our PI refers a poor patient to a government hospital or calls up his peers to explore other options if the latter is taken off the trial or the disease has advanced beyond cure. But what is the option for someone who has exhausted all lines of treatment in the absence of a trial protocol? That’s the reason why we want to do more trials because the intent is not to experiment. It is to cure as far as possible.”

One of the important objectives is to find a new – sometimes breakthrough – treatment. It bodes well for a patient who can access a drug before it is available in the market without incurring any costs, particularly in expensive drugs like Herceptin. “The unique advantage of RGCI is to offer to a patient a drug that is a by-product of the research and offer some treatment if everything else has failed,” says Dr Doval. “I have had people come to me to ask if we have a clinical trial for them although most of them are our registered patients.”

One such patient was Kaushalya who was taken into the trial for a new drug for her kind of cancer.

“In the trial one patient was getting Iressa and the other a placebo, or a non-active drug. At that time, a lung cancer patient in a trial for the 2nd and 3rd lines of treatment got a placebo. We found the results were negative. Consequently, we stopped the trial a year down. The trial was a double blind in which neither I nor the patient knew what drug she was getting,” says Dr Doval. “We did repeat scans for Kaushalya and found her scans had improved. After the trial was stopped, we found she was getting Iressa!”

That’s the time the team started another trial for her in 2004-05 so she could continue on the drug that was giving her significant benefit. However, an investigational new drug cannot be marketed. So, the hospital picked up Iressa from a generic company which had already bought the drug for Kaushalya. She now comes every six months for a review scan. Iressa cost a lakh when it was introduced. It is now 40,000 rupees. Many Indian companies even market it for one-fourth the price. The pharmaceutical company continues to support her and she gets the drug free of cost.

It’s been eight long years since Kaushalya has been taking the drug. She lives now in freedom. The trial against imminent mortality is over.
Second only to Mumbai’s Tata Memorial in the league of cancer specialty hospitals – RGCI has taken a significant step towards advancing of basic research. In May 2013, the hospital became the second medical facility in the country to house a tumour bank or bio-repository.

A bio-bank or bio-repository at the institute is a veritable library which will store and provide cancer tissue and other bio-specimen to investigators for both the purpose of basic and clinical research. A legal luminary and philanthropist, Mr RKP Shankardass has funded substantially the bio-bank geared primarily towards research. Though RGCI is a patient-centric care centre, good research is integral to long-term patient care. It is fundamental to identifying causes and developing strategies for prevention, diagnosis, treatments and cure of cancer. Like a double helix, patient care and research go hand in hand.

“Our clinical research has gained a reputation under Dr Doval, who is the quintessential researcher. That apart, RGCI has forayed into basic research in spite of challenges, particularly funding. The department has been working on various cancers, including breast, gall bladder, lung, colorectal, prostate, non-Hodgkin lymphoma and childhood cancers. It has completed nearly 20 research studies and 10 are ongoing. The completed studies have either been published or presented in conferences and seminars,” says Swarnima Jaitley, Principal Research Officer, in Basic Research.

Given that hundreds of patients come to the institute, RGCI has the unique advantage of harvesting a rich variety of malignant tissues during biopsies and surgeries on a given day. Upon removal, these tissues are sent for histo-pathology or microscopic examination to study the appearance of the disease. The tissue is treated or ‘fixed’ so that it stays true to the life-like conditions and does not decay. But the process also damages the DNA and RNA – the building blocks of life.

A futuristic concept, bio-banks preserve the specimens at minus 80 degrees or more to retain the authenticity of the nucleic acids for future research that can be of immense value not just to the research community but also to the cancer patient.

“Medicine is becoming increasingly focussed on molecular biology. We are now learning about targets in cancer that respond to treatment. The tissues become valuable in finding more and more targets that may be of immense benefit to cancer patients,” says Dr Anurag Mehta, Director of Laboratory Services. “A patient with lung cancer, for instance, may be treated with conventional drugs because there is nothing better that can be offered to him. But years later a new drug comes up. If his tissue has been stored, it may be tested for a target that is amenable to that new drug.”

Conditional to the patient’s life span and discovery of a new drug, the former may reap the benefit of a bio-repository. But given the rate at which targetted medicine is moving, the cancer community may have answers in the near future to problems that riddle its mind today. That however would be possible if the specimens are available and retrievable for research and newer medicine.

That apart, a growing number of patients are being and will be treated upfront with chemo and radiation post a small biopsy made for diagnosis. Surgery may be done subsequent to this treatment by which time the tumour may have either shrunk or virtually disappeared leaving very little for research. The next four to five years are critical to collecting specimens and building a repository for research.

The bio-bank presents in this part of the country presents exciting possibilities for researchers from hospitals, medical colleges, universities, research centres, the pharmaceutical industry within India and abroad. “We will try and make the repository visible, do web-hosting of the available tissues accompanied by relevant clinical information. We have a library now - the readers are welcome,” quips Dr Mehta.
Fifty-two years. A decent government job, wife, two sons, friends and a pack of 10 cigarettes – a regular day for him was filled with professional, domestic and social commitments. On one such day as he brushed his teeth, his mirror reflected a white-looking patch at the far end of the throat, just behind the salivary glands. His elder son had been breathing down his back to give up smoking. He knew the lethal affects of cigarettes. In his heart, he also, probably, knew his health was a few shades less than pink. He had already lost his brother to a neck cancer. The disease had crawled into the nodes and by the time they took him to RGCI, palliation was his only option.

The patch only grew with time. The family insisted on a biopsy. Two investigations in two different laboratories confirmed their worst fears. He had Stage 1 Squamous Cell Carcinoma. And everything that filled his regular day, in 2007, blurred into one long blank.

Their local doctor and some other friends suggested RGCI. Nine years after the family lost a member, they rationalised that a cancer speciality centre would still be the best equipped to deal with the father’s disease. The family met the head and neck surgeon who asked for an MRI to reveal how deep the tumour was. It was in its early stages and the surgeon suggested they opt for radiation therapy instead of surgery.

Gopal Krishna would be treated through IMRT or Intensity Modulated Radiotherapy on the linear accelerator machine, LINAC. Conventional radiation was like carpet bombing. It delivered equal dose to all areas marked in the radiation field with enormous side-effects to the patient. In sharp contrast, IMRT used varying beam intensities, enabling the therapist to ‘carve’ out the edges of the tumour and spare the healthy tissue leading to better cure rates and fewer side effects.

The institute started with quality equipment in 1996. Among other machines, it included one LINAC and one Cobalt machine. The Cobalt was replaced with another LINAC in four years. A couple of years later the centre acquired the LINAC with IMRT and treated the first case in the country with the modulated beam.

“In head and neck area, for instance, there are many normal tissues such as salivary glands. Radiation dries them up as a result of which the patient has to keep drinking water, finds it difficult to speak and eat dry food and becomes susceptible to dental infections. IMRT protects these glands and the patient is saved from the side effects during and after the treatment,” says Dr Sheh Rawat, senior consultant and chief of the head and neck unit in radiation oncology.

Thirty-five radiation cycles for 35 days – the doctors told Gopal Krishna. “The first thing when the patient comes to us is to counsel him. We tell him about the disease, its stage, duration, side-effects, risks, expense and the expected outcome of treatment. We plan his therapy starting with a mask in the case of head and neck tumours to mark the area for radiation. It not only immobilises the patient for treatment but ensures daily reproducibility of the same treatment position. We tell him the side-effects he may have after, say, 10 cycles as we review him in the OPD. If there is an option between conventional radiation and IMRT, we place it before him because the latter also entails a higher cost,” explains the consultant.

Planning is of essence in radiation. It, often, entails hard work to deliver treatment so that critical organs in the radiation path are spared as far as possible. Ironically, technical advances have reduced actual treatment time to a matter of minutes. But the doctors take much longer to listen to and counsel the patient. If the planning design does not meet their exacting standards, they call the patient or tell him in person to come another day.

“The treatment was bearable till 20 cycles. Subsequently, it became very painful for my father. His throat had black marks in areas that had been irradiated and the skin had broken out. He stopped socialising altogether. In the last couple of weeks of therapy, he was virtually on fluids since ingesting food became difficult. We knew this was coming but it was painful to see him in that condition. I was sure the decision of the doctors was good. They had done their job well,” says Partha (name changed), the younger son. “This is a management sensitive to the suffering of the people who come to the hospital and tries to make sure that the patient does not have to undergo more. Reception, doctors, OPD, pharmacy… the systems are sharp and working,” he adds. “I didn’t have to run around or wait unnecessarily. The doctors generally started the treatment with a lot of empathy – explained to us in words we could understand. I felt they had made us a part of their life. There were days, though, when one felt they could do be more sympathetic but their exacting standards, they call the patient or tell him in person to come another day.”
for treating tumours located near vital organs, the inflow of patients increased. Keeping pace with their needs, the institute brought in state-of-the-art technologies.

The next-generation LINAC came in the form of ARTISTE that delivered image-guided radiation, IGRT with Respiratory Gating – a technique capable of synchronising the beam with the patient’s breathing cycle and thin multi-leaf collimators which permit a super-sharp beam leaving the normal tissues virtually untouched.

“Today, RGCI is the only hospital in Delhi which treats about 100 patients every day with IMRT and IGRT techniques. The latest in our arsenal is RapidArc therapy to deliver better, greater results in far less time and Stereotactic Body Radiation Therapy – SBRT – which delivers a high dose to a target in the body in just three to four sittings,” says Dr Sharma.

A radically different way of treating cancers, TrueBeam is the latest LINAC that integrates ‘imaging, patient positioning, motion management and treatment delivery’ to deliver IMRT, IGRT, RapidArc and SBRT – a powerful treatment that is accurate, precise and fast. The technology minimises the possibility of external and internal movement of the body organs obviating, thereby, the possibility of inaccurate results.

“Conventional treatment, IMRT and IGRT require the patient to come for about a month and half every day. SBRT, which is indicated in some tumours, including of brain and lung, and solitary bone metastasis, delivers five times the normal dose in a matter of three minutes instead of 30. It works well for the hospital too because we can treat more patients on the machine,” says Dr Sheh Rawat.
That said top-of-the-line machines require savvy and sensitive men to deliver optimal results. “A breast cancer patient may have had surgery and chemo. Radiation is mandatory if we want to preserve the breast. For her, it is like the end of a marathon by the time she comes to us. She has already lost her hair and her strength. She has burnt a hole in her pocket. We take into account her age, resources and the preservation, in case she has opted for it, of the breast cosmosis. She is not looking merely for cure when she comes to us, she needs total care,” says Dr Sharma, who heads the breast and thoracic unit in radiation oncology. 

Partha was convinced his father was in good hands. “Mareez ko jitti in sujodd de sakta hai, woh jitta doctor ki baat ko trust karta hai, utna aur kisi ko nahin. If the doctor radiates compassion, hope and strength to the patient, it is like dual therapy and can work wonders for the patient.” The son took back a healed father – and the scars began to gradually fade away.

Five years later, in early 2012, Partha’s mother was detected with Stage III ovarian cancer. The news was a double distress to the family.

Today, our OTs and the LINAC machines are on different floors. In the new block, we propose to have OTs adjoining the machines that will facilitate what is called the Intra-operative Radiotherapy. IORT enables radiation to be administered during surgery. As a dedicated cancer centre, we keep pace with the latest technology and so plan to develop this facility in the next few years.

Dr Sheh Rawat

All this while, Gopal Krishna had been doing well at his reviews. But early in the year, an irksome cough began to pummel his body. By the time the mother’s chemo began in April, also at RGCI, Gopal Krishna had reached a point where he found impossible to eat anything at all. Back in the hospital, Dr Sheh Rawat recommended an endoscopy.

The intruder had returned – to encroach upon a different location near the vocal cords. The PET-CT ascertained the tumour had reached the nodes. But this time, radiation held only 50 per cent chance of cure. And there wasn’t even a pale beam at the end of the tunnel if it failed. Besides, a second-time radiation was constrained for the areas it could treat and the dosage would be limited.

Take a surgical opinion, the therapist advised. The opinion that came stunned the family into silence. The father would have to go through a laryngectomy, removal of the voice box. “That wasn’t an option for us at all. We took a second opinion in favour of radiation and chemo. The learning was we needed to look at the positive 50 per cent and take a chance – just what we wanted to hear, I suppose. Quality of life follows life, Dr Sheh Rawat had said earlier. We returned to him,” remembers Partha.

The second round of 27 IMRT fractions is over. The intruder is beaten and Gopal Krishna has won the second round too. He has returned to work and friends. Other than some dental pain, life is kind. Dr Sheh Rawat says some hoarseness in the voice may stay behind as part of the new normal. “He is a practical, very experienced man,” says Partha about their clinician. “We had been recommended IORT in another hospital for the second round – perhaps because the treatment cost goes up by a straight one lakh. But our doctor stood his ground – IMRT was the best for my father. Patient par focus tha, paise par naahin. I am thankful we came here, and happy that both my parents are well,” the intensity in his voice not modulated for any effect.

Dr Sheh Rawat

O ur first patient on the first LINAC came with oral cancer. The machine was new to us and we were new to the machine. We fussed around him – told him to lie down, put him on the simulator, planned for him… did the rounds with him! The patient, naturally, got a little impatient and asked us if we would be able to treat him at all. I was trained on a different technology when I was at Tata Memorial. The LINAC was really the finest at the time but we were still getting to know its nuts and bolts. We gave him the confidence that the best would be done for him. When we took him for an MRI, everyone again stood around him out of curiosity. “Am I the only patient here,” he asked rather disconcertedly. This maiden visit created so much excitement that our calculations as to the dosage went awry. AVM Kapur and Mehta Sahib came rushing to the hospital. The next day, we compensated by balancing the dosage. While the machine was the latest and equipped to handle human error, it wasn’t computer-controlled like now. We performed a small goodbye puja to express our gratitude to the machine that helped us treat 65 patients every day till the new LINAC came in.

In fact, we did not have an inbuilt computer for our first LINAC. We had to make physical shielding blocks as per the contours of the patient. Like ironsmiths, we worked with an alloy to make the blocks. The block was kept between the machine and the patient so that the best radiation dose could be given to the tumour without harming the normal tissue. We would make 15-20 blocks for a single patient depending on the angle of the radiation – and we did this for all types of cancers. These blocks were rather heavy. My colleagues would jokingly tell me they were losing weight lifting them. I discussed the matter with our then HOD, Dr AK Anand, and we decided to give a ‘block-lifting allowance’ of 1200 rupees to all those who worked on this machine in 2003!

GS Wadhawan
Radiotherapy Technologist

Below: Shielding blocks that were used earlier to protect areas of the patient’s body. Currently personalised synthetic masks are being used for the same purpose.
Hepatocellular Carcinoma. It was a term alien to Mrs Veena Anand, wife of SK Anand who had been complaining of a nagging pain on the right side of the abdomen. Regular treatment was a letdown. The pain persisted and the family pushed Mr Anand for an ultrasound. “Tell me in plain language, I said to him when he got the report,” recalls Mrs Anand. He told her.

It was primary liver cancer – one that begins in the liver. For the banker who was 50 when his treating doctor and, subsequently, PGI Chandigarh, confirmed the diagnosis, it was a moment of despair. He had decided he had hit the end of the road. Mrs Anand saw it differently. “I just did not feel the need to ask anyone for a prognosis. It was a mixed feeling... I can’t say I was depressed. But it didn’t feel as though my world had crashed. I just had faith,” she says.

Inquiries on the internet offered promise of another kind. By January 2005, Mr Anand had been operated upon in the left lobe of the liver in a Delhi hospital acclaimed for liver surgery. A CT scan post surgery confirmed a lesion in the right lobe. It could be dealt with by a procedure called Alcohol Ablation, the surgeon told them. Chandigarh was home and PGI offered the procedure. They returned to discover that Alcohol Ablation had been futile even after two rounds. “I went back to the internet and found out about Radio-frequency Ablation. Doctors at PGI said the results of the technique were much better than Alcohol Ablation but they did not have the facility. Around that time, a friend of mine told me about Dr AK Chaturvedi at RGCI.”

The couple met the Head of the Department of Radiology – a spirited ex-army man, with an easy air. He was positive and supportive, remembers Mrs Anand. Such stray tumours in the liver could be tackled by RFA, he told them with remarkable light-handedness, and the patient could lead a good life. Even though recurrence couldn’t be ruled out, “but we will tackle it when it happens,” he assured them. It was a confident, empathetic hand that held Mr Anand’s hand. It belonged to an institute that had pioneered 10 years ago the innovative technique of Radio-frequency Ablation to destroy tumours without surgery. Radio-frequency Ablation, or RFA, is a relatively new treatment modality in cancer where thermal energy is used to destroy cancerous tissue. Minimally invasive, RFA is eminently successful in treating small primary liver cancers as well as metastatic liver cancers. The technique is optimally used for a patient diagnosed with primary liver tumour that is less than 5 cm in size and has five or less lesions.

“A needle-electrode, connected to a generator, is inserted into the lesion. The current passing through the patient heats up the tissue and the tumour is cooked to death,” says Dr Chaturvedi.

Image-guided interventions such as FNACs, and breast and other biopsies to confirm cancer in deep-seated parts of the body have gradually evolved to RF Ablations, an image-guided therapy, at RGCI. Interventional radiology began with the intent to diagnose. A needle was inserted under guidance at a point...
in the liver. Now, the radiologist does exactly the same thing in RFA—except that this time the procedure directly treats the patient. The team of radiologists has done close to 200 ablations in the last 10 years to put RGCI on top of the RFA map in North India and take radiology beyond diagnostics.

“Team work is central to RGCI,” says senior consultant Dr Avinash Rao. Our Tumour Board decides if this is, indeed, the best therapy for the patient. A patient who has undergone surgery of the liver or the colon and is plagued by another tumour in six months is tired. He receives RFA because it is the ideal therapy for him, not because he has been referred to us.”

“I differ from those who view radiology is a non-clinical speciality,” Dr Chaturvedi opines. We are now getting patients directly... the patient comes to you with many, many questions. You have to answer them based on evidence worldwide. You have to counsel him because there are risks involved. You have to share them with the patient. I and my colleagues will take that risk if the advantages outweigh the disadvantages. It is not about fixing responsibility alone – consequences are part of any treatment. But the patient will become your partner if you take him into confidence,” he says.

When they first arrived here, the Anands were convinced they had come to a good place.
“The MRI alone doesn’t solve the problem,” says Dr AN Jena, the man who initiated MR-guided breast biopsy at RGCI. “It is an extremely sensitive technique that sees, for example, all lesions in the breast that other imaging tools don’t. The breast tissue, unlike other tissues, is a highly complex structure. Not all things that you see in a breast image are cancer. The lesions have to be characterised as cancerous or non-cancerous – and for this one needs restraint. Only histology can prove it. So MR ‘sees’ the lesion without which you cannot target it in any modality. This can be nightmarish for both the patient and doctor. But biopsy alone confirms its malignancy or otherwise. So, the patient and the doctor have a choice if you have the biopsy apparatus in your armamentarium. The doctor may do the biopsy if necessary. But the capability itself is very essential to be developed. I started Breast MR in India in 1986 at INMAS and would have done 100 cases in over a decade there. People, then, went to Singapore for biopsy. When I began MR-guided breast biopsy at RGCI, we saw 2000 patients in the same time. If we saw a lesion that wasn’t good looking, we could help the woman here at RGCI. This was, for me, genuine practice.”

It has been seven years since. He has been through eight or nine ablations following recurrences. The PGI, Chandigarh, now offers RFA. But the couple drives to Delhi every time his doctor asks them to. “I trust Dr Chaturvedi more than anyone else because of his experience. I get my CT scans done here even though the facility is available everywhere today. I feel I am aligned well with my doctor. He and his team tell me everything. I share with them if I come across something new. They talk to me, educate me. I feel like half a doctor already,” Mr Anand laughs.

That laughter is a good sign – of experience holding a great potential for empathy. Technology has grown by leaps with each new case of interventional radiology in cancer. Once risky and sometimes ambiguous procedures of biopsies and FNACs now have a yield rate in the range of 96 per cent at RGCI. But more than that, the radiologist has stepped out of the shadows of scans and x-rays to know the patient a little more intimately.

Mr Anand says he feels a surge of energy each time he speaks to his doctor. The couple calls him to wish him on festivals and he returns their calls. They have his personal number on which he is accessible any time of the day or night. But it is the doctor’s faith that strikes a strong chord with Mrs Anand. “Every time there’s been a recurrence, he has always said – ‘no problem, we will tackle it’.”

A good radiologist thrives on suspicion. His mind needs to know for his eye to see. The patient, on the other hand, must ride on faith, knowledge that is beyond the reach of proof. Mr Anand agrees. He is hale and hearty as Dr Chaturvedi calls him, the ‘star performer’ of the RFA team. For him, they are a group of men and women who have embraced him as part of the family and cured him.

Ironically, suspicion and faith have matching frequencies when the doctor and patient tune in together.

It was early days at RGCI. Interventional biopsies to confirm cancer in deep-seated parts of the body were not being done anywhere in the city. Breast imaging or mammography to detect early breast cancer was a novelty. The hospital acquired a top-of-the-line machine with a stereotactic biopsy unit equipped with a small mammography unit. The equipment combined the features of diagnosis and biopsy of the breast. The special mammography machine used x-rays to precisely guide the radiologist’s instruments to the site of the tumour and for tissue sampling.

Today, the hospital is fully equipped for comprehensive breast diagnostic services. Their reports indicate the level of suspicion for cancer based on American College of Radiology BIRADS categories. Apart from the ultra-sound guided FNACs and biopsies, stereotactic biopsy procedures and guided wire localisations are also performed. In case, an abnormality is detected on MR Mammography, RGCI also has the state-of-the-art MR-guided biopsy system.
A
t elderly man, diagnosed with lung cancer, got a PET scan for the purpose of staging from outside RGCI. The institute did not have the facility at the time. The equipment was rather expensive and its affordability was questionable. Staging, which accounts for the size and extent to which cancer has developed by spreading, is critical to correct treatment. We first started thinking of acquiring it in 2004 when its role in cancer treatment had begun to be recognised.

After, the initial scan he was prescribed radiotherapy as the primary modality of treatment as his scan did not show any spread of the disease beyond the lungs and surgery was not possible. Four, or perhaps, six weeks after radiation therapy, his scan was reported as ‘progressive disease in the lungs’. The radiation oncologist was in a fix since the report did not correlate with the patient’s improved condition.

The radiation oncologist asked me to look at the scan. The patient was heartbroken and his daughter in tears when they came to me. I asked him how he was feeling after the treatment. He was symptomatically 70-80 per cent better, he said. A comparison of the two scans revealed that while the findings were right, their interpretation was wrong. I explained to the patient, his daughter and the clinician that the scan showed post treatment changes. Contrary to what had been reported, the tumour had, in fact, shrunk! The second scan had been done earlier than it ought to have been and it showed an ‘apparent worsening’ due to post-treatment inflammation of the organ.

This incongruity was one of the many where reports hardly matched with the clinical condition of the patient or our standard teaching. We, at RGCI, would have a tough time reviewing similar cases and on many occasions the interpretation was completely reversed. However this was only possible because of our close interaction with the patient and the clinical faculty. A government-run facility in Delhi was the first to get the PET. While it was a learning curve for them too, we were trying to find out ways to interpret the PET scan correctly and at the same time see where they were going wrong. Clearly, it was as important to understand the limitations as it was to identify its potential and strengths. Within a year of its commissioning at this particular institute, the enthusiasm was dwindling and the modality going into disrepute because clinicians had started doubting its utility.

When we started in 2008, it took us a while to undo some notions about the PET in the clinicians’ minds. We burnt our fingers, too, but worked hard towards making the facility an instrument of utility for our clinicians. My earlier experiences of conflict between the report and its clinical correlation taught me the importance of treating a patient, not his reports. Merely reporting or seeing a finding in a PET scan was useless unless one was able to interpret the finding in a given clinical scenario. We discovered that the same findings in two different patients may not have the same interpretation and all that was active in a scan may not always be cancer.

But pre-2008, when the institute was mulling the purchase of the PET, we accidentally got the information that they were planning to outsource the machine. Outsourcing meant the equipment would be financed and run by someone else. In fact, even the MRI and CT scan were being considered for subcontracting to the same diagnostic centre. A series of discussions convinced the management that outsourcing was indeed on the cards. The consultants went into a huddle. They were sure of the viability of the machine, they said, and proposed they would jointly buy this equipment if the management was short of funds.

Seven years ago we nearly ‘lost’ our first PET. Today, we are in the process of acquiring a second one because of an overload on the first!

Dr PS Choudhary
Director, Department of Nuclear Medicine
The disappearance of an aggressive systemic cancer via a chemical drug was virtually unprecedented in the history of cancer. In the summer of 1948, when one of Farber’s assistants performed a bone marrow biopsy on a leukemic child after treatment with aminopterin, the assistant could not believe the results. ‘The bone marrow looked so normal,’ he wrote, ‘that one could dream of a cure.’ And so Farber did dream. He dreamed of malignant cells being killed by specific anti-cancer drugs and of normal cells regenerating and reclaiming their physiological spaces...

It is a mystery how dreams can travel from a Boston clinic of the late forties to Bihar of 2012. On the one end is a pathologist cooped up with his small team, fiercely trying to unravel the mystery of chemotherapy, especially for children; and on the other, is a poor family with two cows and a patch of farm land struggling to save their 6-year-old boy from leukemia. The doctor in Patna tells them of a hospital in Delhi where their child can be made well. A few months later, on the wings of the dream and some money, Luv Kumar travels to the hospital along with his grandmother and uncle.

“Ab to bahut theek bha aur ab hum ghar jaayeb,” says the grandmother, Renu Devi, and smiles, though still somewhat nervously. It is a smile that has traversed a tough path – of fear, hopelessness, tears, confusion, relief and hope. It is a smile that she shares with 3-year-old Raunaq’s mother Sunita, 6-year-old Sonia’s father Israr Ahmed, 11-year-old Nikesh’s mother Sangeeta who came from Nepal and thousands of parents. They have seen their young girls and boys wrecked by leukemias, lymphomas, brain tumour, hepatoblastoma, Wilms Tumour, neuroblastomas, bone and soft tissue sarcoma... and found cure and care at RCGI’s Department of Paediatric Hematology and Oncology.

These smiles are precious for the team led by Dr Gauri Kapoor who has worked hard to see to it that Luv and children like him return to school and lead as normal a life as is the right of every child. They have treated them for heartbreaking conditions that may otherwise be linked to high mortality rates.

“Children normally need more attention – children with cancer more so. You need to have a rapport with them to ensure they follow your course of therapy. It is a tough treatment and needs a lot of supportive care from physicians, paediatric oncologists, nurses, counsellors, lab, blood bank etc. Among leukemias, for example, Acute Lymphoblastic Leukemia or ALL is the commonest and takes about two to three years to treat. These are precious years, the time of growth, play and work – during which we have to keep the child’s education, her childhood going. Here, we aren’t just curing cancer. We are trying to take care of a child who has just about begun and has many,
“Resolve to be tender with the young, compassionate with the aged, sympathetic with the striving and tolerant with the weak and wrong. Sometime in your life, you will have been all of these.”

Gautama Buddha

many years ahead,” says Dr Gauri Kapoor, Director and Head of Department of Paediatric Hematology and Oncology.

Paediatric Medical Oncology, virtually non-existent in the early nineties, was still a new concept at the time when Dr Kapoor founded it in RGCI. Before the establishment of Paediatrics as a separate branch of medicine, doctors for adults treated children. So was the case with oncology. Children, often, received suboptimal therapy as they were treated by oncologists or paediatricians without any special knowledge of pediatric oncology. Dearth of quality paediatric cancer units and multi-disciplinary or protocol-based care could have as well been non-existent.

The country had a long way to go before catching up with the West on paediatric cancer services, research and education. Dr Kapoor, with a background in Tata Memorial Hospital, Mumbai and St Jude Children’s Research Hospital, USA, started one of the first dedicated paediatric cancer units in North India in the nineties – at RGCI.

Today, the department comprises experienced pediatric oncologists and haematologists, paediatric onco-surgeon, radiation oncologist, paediatric oncology Fellows and paediatric bone marrow transplant facilities. This apart, there are two additional nurses, specially for the department, to oversee treatment orders, the administration of the complex procedure of chemotherapy and care of central lines through which drugs are given. The department also boasts of a playroom teacher and a psychologist. The playroom has colourful books, toys, computer and television. The children, either admitted for chemo or for day-care procedures, draw in a breath of fresh air as they make things with their hands sitting in funky furniture, fool around, read, laugh a little, tackle Playstation and break the monopoly of cancer for that time. The counsellor engages with children for IQ levels and with parents to inform them, ease them of their worry and fears. Unlike in the usual private sector hospital, all these facilities,
to do this with a 50-yr-old patient. He wants to live and knows the consequences of non-compliance. But an adolescent’s world is made of different stuff. You’ve got to empathise with him and befriend him before he submits to treatment and sticks to it,” says the veteran of many listening sessions.

If the Aristotelian maxim – to perceive is to suffer – be true, it would be tough for a dedicated paediatric oncologist to know that only 15-20 per cent of the 50,000 children who develop cancer each year are able to reach a cancer unit. Of these, 40 to 50 per cent drop out of treatment.

The overall survival rate for childhood cancers is around 90 per cent if treated. But the doctor is uncomfortable not knowing why the remaining 10 per cent fail. It bothers her that she has to treat the children so aggressively. She wants lighter treatment to protect the child’s immunity so that life is relatively free of infection, skin rashes, bleeding gums and high fevers and that isolation doesn’t become loneliness. But intensive therapy is a must because it is the only way the child can be cured today. The only redemption is that children tolerate chemo much better by virtue of being younger and healthier than adults who may often have parallel health issues.

In keeping with the international protocol, RGCI has redefined paediatric oncology to embrace young people of up to 18 years in whom cancers are similar to younger children. “But you cannot force their mouth open and push in a pill. Compliance is an issue with adolescents,” says Dr Kapoor. An 18-year-old can stop taking 6-MP, one of the most active anti-leukemia drugs, because “it does something to my body.” Just like that. And no one even knows. The cancer relapses and he returns to them. This time, she asks him if he really wants to be cured. “You don’t have
really sick while waiting for his evaluation. The doctors may give chemo in day care, but a sick child, often, needs admission. Even if they want to admit him, a bed may not be available,” says Dr Jain.

RGCI is one of the few hospitals to have dedicated beds in the Paediatric Department. “We are grateful that we have a perceptive management. Our patients are always accommodated elsewhere if necessary,” says Dr Kapoor. While administering chemotherapy is a difficult process, the tougher battle is in dealing with its complications. A child brought in with fever, bleeding or similar issues is in no condition to wait. Dr Kapoor, Dr Jain or one of the Fellows in the department’s 2-year Fellowship programme takes him to day care which is open 12 hours a day. “It doesn’t matter how big the patient is. It matters how big the complication is. If it is preventable and treatable, there is nothing that’s not done here to prevent and treat,” says Dr Kapoor, who may be easily mistaken for a kind, amiable healer of the days gone by.

To Nikesh’s mother, Sangeeta, she is that. “Always considerate, never a harsh word… and the only time she got angry was when I reported late for my child’s treatment.” Nikesh was put through chemotherapy to shrink a tumour in the chest before Dr Kapil Kumar removed it surgically. “I have stayed by myself for four long months with my sick child,” and she breaks down yet again. “I didn’t know Hindi very well but not once did I feel I wasn’t at home. My son is quite well now. His reports are all fine but we have to return for follow-up and inform Gauri Mam about his blood reports. But in moments of anxiety, I have called Dr Sandeep Jain from Nepal – and he has listened, given us hope and cheered us up.”

Spatial distances matter little when a parent instinctively knows a particular doctor is the next best thing for his child after God. “Koi baat hoti hai to turant lekar yahan aa jaata hun… I don’t call, I just get her here,” says Sonia’s father, a small-time tailor. He was terrified when he got to know at first that his girl had blood cancer. “I felt so totally helpless. But as soon as I came here, Gauri Mam said to me my child stood a 90 per cent chance of complete cure provided I worked along with them. Her associate Dr Anshul sat me down and took time to explain in detail what to do and what to expect in the course of treatment. The counsellor and nurses helped me fill the form to apply to the PM Relief Fund. Gunjan Mam and Pankaj Mam (counsellor/teacher) came home to see Sonia. Now when I come here for her routine check-up, my child is happy to be left with them if I have to do some necessary errands. And to see her well and happy is all that matters to me.”

It’s what matters to all parents and caregivers. Many may not know the names of the cancers that have struck their children. Most may not understand the complexity of the treatment. They may know little about the significance of cancer research and academics that happens in big centres but who put patient care on low priority… perhaps even less about institutional protocols which take years before they are approved and begin to benefit patients.

But their heart knows something more essential, perhaps. Like the grandmother from Bihar who knows that there is a hospital whose doctors are concerned enough to ask her “Kyun mukh maleen hai aapka?” (Why do you look so pale and worried?) That the entire team will support her in all possible ways, make special concessions, see to it that she doesn’t have to pay for her board and lodging and help her through a difficult journey. She is taking back her grandson where his great grandmother, parents and siblings wait to see him. It will be some time before their foggy eyes clear up and faint smiles breach the uncertainty barrier. It will take some years before Luv Kumar is cleared of cancer. But their son is shining again. The bright little boy can now start planning a new set of pranks to play when he goes back to school. He can start to dream again.
She supplies warmth and sustenance to her foetus, her heartbeat soothes its heart. An exchange through the placental link and, later, nursing, enables the integration of their cells with each other’s bodies. What’s seen as ‘two’ continues as ‘one’ in many ways. That’s an ancient miracle.

And then there is a modern, medical irony. A mother’s bone marrow cells may refuse to recognise her child’s body and treat it as a ‘foreigner’. Harvested to give him life, they also launch a lethal attack on his immune system if not matched fully, causing him ailments and infections of various kinds. It can be heartbreaking for her, as it may have been for Ashutosh’s mother.

But Ashutosh Dixit, 21, was made of sterner stuff – stuff that found a perfect match in a competent transplant team of the hospital. “I was always very positive – right from day one, khush rahta tha,” recalls the spritely boy with a dark, curly mop on his young head. “I thought I had come to a strange place when I saw the doctors all super serious. But gradually we broke the ice. Dr Dinesh Bhurani and Dr Shishir Seth would hardly speak to me about my illness. Dr Seth would talk of his ice-cream treats after I was discharged and Dr Bhurani would ask me about my college and the sports I played.”

It was after a series of multiple admissions, infections and transfusions that Ashutosh came to RGCI with severe Aplastic Anaemia – a blood disorder in which the bone marrow ceases to make new blood cells. And sometimes, it may all but terminate life. It nearly did in 2010 as it threatened the 19-year-old boy who was pursuing a graduate course at Motilal Nehru College, playing football, driving his Yamaha, gorging on momos, dancing and dreaming of cracking CATs and MBAs.

A year and several failed injection therapies after, Dr Bhurani told the Dixits of Allogeneic Bone Marrow Transplant. It was “temperamental, tricky and mercurial” with even a fully matched bone marrow. But Ashutosh’s transplant was far riskier. “We couldn’t find a perfect match within his family or outside. The results of earlier treatment were not encouraging either. His mother’s marrow was only a half match. The risk of infection is very high if the donor’s marrow is not fully matched, or what is called the Haplo transplant. But we were losing Ashutosh when...”
he came to us. It was a drastic step – we told the family and decided to take it,” says the senior consultant and head of BMT unit at the hospital.

The gamble paid off. Dr Bhurani and his team performed the transplant on October 17, 2011. Ashutosh was on his way to becoming the first patient in Delhi to be cured of Aplastic Anaemia through half-matched bone marrow transplant which is still very rare in India. Post the transplant, he developed the common, potentially fatal complication HVGD (Host versus Graft Disease in which the donor’s cells strike the host’s), lost his gums and got repeated skin rashes.

His mother, who once again gave life to her son, chokes as she re-lives the agony. “I know the worst is over… takleef hoti hai ki ye kuch kha-pee nahin sakta, kahin jaa nahin sakta. Par aas takleef hoti hai ki bimar hai…”

All, indeed, has gone well. Elder sibling Rahul’s bone marrow also did not match Ashutosh’s but he complements the younger one perfectly. “Seeing Ashutosh, it is impossible to know he has been through so much pain. Laga hi nahin ki bimar hai,” says the proud brother.

In spite of the intensive chemotherapies, endoscopies, biopsies, pain, restraint... the essential marrow, his spirit, is intact. The month-long isolation post surgery only endeared him to the nurses who looked after him at the time. “Sister Nitya gave me a wrist watch for my birthday after my transplant. Sister Sweetie and everyone else say they miss me and ask me to meet them whenever I go for my review. Some of them have also invited me to their wedding down South,” he grins from behind the mask that he has worn scrubulously for over a year to fend off infections and removes only in the privacy of his little room.

Dr Bhurani acknowledges the ‘tapasya’ of the family. “He is doing well now and we are nearly at the end of his treatment,” he says with relief. Ashutosh must still chew his food from the right side until his gums grow back. But he is already looking forward to resuming his final year studies from home. There is MBA to be done so he can “set everything right, including all the expenses my father’s has had to make”. The terrace of his house awaits his footsteps as does the bike its rider. The ice-creams have frozen in time for him and the momos are holding their fire till the boy who renounced it all returns to them yet again.

Since the addition of Bone Marrow Transplant facilities in 2001 to Medical Oncology services, the unit has performed 250 successful transplants. These include Autologous Stem Cell Transplants as well as Allogeneic Bone Marrow Transplants done at very cost-effective charges. With 70-80 transplants every year, RGCI is the largest BMT unit in North India’s private sector.

The unit offers transplant facilities for malignancies such as lymphoma, myeloma and leukemia and also benign conditions such as aplastic anaemia and thalassemia major in adults and a large number of children.

Autologous transplants involve harvesting the patient’s own healthy stem cells and frozen till they are transplanted back in the body. In the interim, chemotherapy and, sometimes, radiation is used to destroy the malignant cells, which also wipes out the stem cells in the bone marrow. The harvested stem cells are then returned to regenerate and replace the destroyed stem cells. Allogeneic transplants use a related or an unrelated donor for matching the stem cells to make a successful transplant. Siblings are preferred donors.

Led by senior consultant Dr Dinesh Bhurani who is the first DM of Haematology in the country, the unit added the far more complex allogeneic transplants post 2007. The unit has also done some Haplo transplants with half-matched marrow cells. The procedure, still rare in India, has been performed with internationally accepted results.

Comparable to the best anywhere, the unit offers rooms with strict isolation to protect the recipient against donor cells, rejection and infections. “Our infection rates are far less than several corporate hospitals in Delhi,” claims Dr Bhurani, who is Fellow of the Royal College of Pathologists of Australasia in BMT and haematology specialist. It is backed by highly qualified and experienced team of medical and paediatric oncologists, a large, dedicated team of nurses and a blood bank for blood and components.

While chemotherapy alone cures blood cancers in most children, adults stand only 30-40 per cent chance of cure without a transplant. Two-thirds of all adults with blood cancers require a transplant. All myeloma patients need transplant after chemo and as do relapsed patients of lymphoma. Vital statistics such as these places the BMT facility at RGCI in a critical role.

The Graft versus Host Disease usually affects the skin, liver or intestines but can be serious and life threatening in a fraction of patients. Once it occurs, it does not mean that transplant has failed. In fact a mild degree of the disease may be helpful in better control of the cancers as these donor cells which are reactive against the normal tissues of the patient also counter cancer cells and destroys them.
Shabnam Shafi undertakes a slightly different journey as she goes back home to Aligarh after nearly two years of being in Delhi for her sister Tamkeen’s BMT for Acute Myeloid Leukemia.

Her association with RGCI begins in 2011. The daughter of a lock-maker father of 13, she decided to bring the littlest of her 10 sisters to Delhi. Several rounds of alternative medicine had failed to bring down Tamkeen’s obstinate fever. The local doctor hinted at cancer and advised the family to take her to RGCI. Bone marrow and other investigations confirmed that the 12-year-old was among the 15 per cent children who are afflicted with Acute Myeloid Leukemia, a rare malignancy of the white blood cells.

Just a month of chemotherapy hushed the din of white blood cells in the bone marrow. Tamkeen cruised into miraculous remission from a disease that needs five to six months of aggressive chemotherapy. The cure rates were 50-60 per cent as in all children with AML, which could relapse owing to certain high-risk factors. The doctors needed to consolidate the gains made in the first cycle of therapy. But the unwilling father stifled all protests. The family returned to Aligarh. A year went by.

With some homespun treatments going on the side, Tamkeen regained her chubby cheeks. But soon the old fever stalked back, with her compromising up blood.

The disease polarised the family which returned to the hospital, this time without the father. “He did not want to continue treatment because he believed it would be a complete waste of time and money. I knew it was money, not time, that was the real problem and I told him so. Tab ham sabne pucca irada kar liya ki chahe kuch bhi ho jaye, kuch bhi bechna pade, ab lautenge tab jab ye bilkul theek ho jayegi,” says Dr Kapoor. “The family was uncertain of our staying back this time around and I understood why. Her team had worked very hard for the first cycle of therapy – and then we left all of a sudden. Lekin main to yahi kalungi itnai ke zamane mein unke jaise doctor milna bahut mushkil hai,” says 21-year-old Shabnam, who came here with sisters Shama and Shayada, and brother Saddam.

“One is a lot of counselling that precedes the treatment,” says Dr Kapoor. “The family returned after a year, with the child suffering from severe complications. But this time the sisters stood their ground, certain they would see to it that their little sister is cured.”

And they did. It would need more than chemotherapy in this second round. Tamkeen would also have to undergo an Allogeneic Bone Marrow Transplant. The procedure would replace the abnormal cells in her bone marrow with healthy, blood-forming cells from eldest sister Shama’s marrow which completely matched with those of Tamkeen.

Dr Kapoor’s team successfully carried out on 22nd December, 2012 the process that runs a higher risk of serious side-effects.

The family received substantial help from both the PM and CM Relief Funds. The ‘super’ sisters traded their jewellery and fixed deposits for their younger one’s life. The father was so miffed that he did not visit them even once. Neither did they go back home. Shabnam’s brother suggested they treat her at a government hospital. But she put her foot down – she did not want her sister catching infections in hospitals packed like sardines. “People in this hospital have cared for my sister like their own. She would develop fever, infection and cough after the transplant. The nurses would just hold the basin in their hands when she threw up. They would apply cream to her sore skin as soon as they saw it. Par unki head jab aati hai… irise bado hospital – kahin mil jayen, itni himmat deti hain, sanjhaisai hain, koi kuch kahe, aap sirf treatment par dhyan dena, Gunjan aur Pankaj mam….” her eyes speak volumes even as she tries hard to complete her broken sentences.

There is a lot to mend, however, when they return. Will the father accept them? “It’s more of a question of whether we will accept him,” Shabnam says defiantly. She and her brother have to go back to their respective colleges. They haven’t told Tamkeen about how her elder sister’s blood, quite literally, flows through her veins. Nor about the ‘senser’ (as Shabnam calls ‘cancer’) that kept her in the hospital and away from home for months together. She only knows that her sister and brother have done just about everything possible for her, given in to her tantrums, fulfilled her every wish. He bought her a fancy phone and a laptop while Shabnam, like a mother, cooked for her, fed her, bathed her. Together, they have battled – and vanquished – a dreaded foe, under the care of an institutional parent.
A good surgeon is an artist, a musician... I have seen some French surgeons in action – it is like they are writing poetry,” says Dr Sudhir Rawal, Head of Uro-Gynaec Surgical Oncology, and Director, Surgical Oncology. “A bad surgery is like a bad song,” he smiles, “but a good surgery is like a lyrical song – you enjoy it.”

If good surgery be poetry in action, robotic surgery should come closest to being a sonnet, a poetic form that is “lax enough to permit freedom of expression but restrictive enough to be challenging, long enough to allow detail but short enough to force conciseness...”

Sonnet or no, to know that a nimble-fingered robot was going to ‘handle’ his surgery would have taken the edge off Lt-Gen KK Lakhera’s diagnosis of prostate cancer. “I knew a little about the robot – the treatment is specific to the part which has the disease. It can pinpoint that part and drill holes in a few places to remove that part,” says the decorated soldier of the Indian Army.

The robot was a lot more. It was a triumph over the several failings of both open prostatectomy and laparoscopic radical prostatectomy. Gaining ground as the most famous robotic prostate surgery – Robotic Radical Prostatectomy – it was available through the Da Vinci Surgical System. A less traumatic and minimally invasive option for remedying and removing a malignant prostate, it meant less pain, smaller blood loss and shorter hospitalisation. It cut back the risk of incontinence and impotence and enabled faster return to normal activity.

With the advent of minimally invasive surgery and post laparoscopy, it was a futuristic advance in surgical technology – the first of its kind in an exclusive cancer hospital in India. Over 150 robotic surgeries had already been performed by the team of surgeons since the da Vinci Robotic Surgical suite was added to the armamentarium of surgical facilities of RGCI in 2011. A little after, around March-April 2012, the General called the hospital.

Post his retirement from the armed forces, General Lakhera was sent to Pondicherry as Governor and was given additional charge of Andaman. He relinquished office as governor of Mizoram. It was during that time that the alarm bells had started ringing. But he was then battling his wife’s brain tumour. It would be on his return to Delhi that he consulted his friend and doctor who advised an immediate PSA – the Prostate-specific Antigen test, an investigation widely used to screen men for prostate cancer. “It was 6 when it should have been below 4. I had ignored the warnings. Now, I needed to consult a specialist,” General Lakhera details clearly the sequence of events.

“We have a very fine surgeon but he is travelling soon. Why don’t you come right away and we can get the process started,” offered Mr DS Negi, the CEO of RGCI, who...
was Chief Secretary during General Lakhera’s tenure as Lieutenant Governor of the Andaman Islands.

The ‘fine’ surgeon the CEO was referring to was Dr Sudhir Rawal, who started up robotic surgery at RGCI on 28th February, 2011 apart from launching several other firsts. A protégé of Dr KK Pandey, Dr Rawal is, perhaps, one of those surgeons who have a taste for challenges. Sixteen years ago he was the first to do radical prostatectomy, a rare and chancy surgery that no hospital in the country’s private sector was doing at the time.

Perineal Radical Prostatectomy – the first in India – followed which requires a surgeon to approach the prostate from the region between scrotum and anus. While it was being routinely done in the US and Europe, the surgery wasn’t popular in India even though it had the least morbidity. An uncommon surgery, it is now becoming rarer because the robot has taken over virtually all in the area of prostate surgery. In 2006, Dr Rawal innovated what is now famously called the Pitcher Pot Ileal Neobladder, a technique which involves the removal and reconstruction of the bladder and has found its way into leading urology journals. He is currently doing the maximum number of neobladders in South-East Asia. He would go on to perform the Minilap Radical Cystoprostatectomy which entailed the removal of the bladder and prostate from a small 8-12 cm incision – the first in the world to do so in 2008 and receive peer credit from fellow surgeons in Denmark. “This is a difficult one again, not very popular and most surgeons would be a little out of their depths. The beauty of Robotic Surgery is that it makes a surgeon very comfortable,” says Dr Rawal.

If the ergonomic robot allows the usually standing surgeon to operate from a seated position at a console and greater autonomy, it also puts the patient at ease. The General knew that the hand that would perform the surgery belonged to the robot and obviated the tremor of the human hand. But the man – quite literally behind the machine – was no less sure. He had dealt with a steady stream of patients and performed similar operations in his surgical career of 16 years – from open, to laparoscopy and now, the robot. “He was like a good orthopaedic doctor in the Army who is difficult to surpass quite simply because he deals with broken bones day in and day out,” laughs the General.
Dr Sudhir Rawal asked for some investigations, including a scan of the abdomen, when the General came to RGCI. Once malignancy was confirmed, they needed to know its extent. A full-body scan and some quick diagnostics later, Dr Rawal led a team of three other doctors to operate him for Robotic Radical Prostatectomy.

“In the first year since we started the Robotic Surgery, we did 160 cases. The number climbed to 250 the next year. These include Radical Prostatectomy, Radical Cystectomy, Radical Nephrectomy, Partial Nephrectomy and Radical Hysterectomy. Dr Kapil Kumar has deployed the robot in the Thoracic unit as have our GI and Head and Neck surgeons. I am hoping we will do 600 robotic surgeries starting next year. As of now, we are doing the maximum number in the country anywhere, including private and public sectors in oncology,” says Dr Rawal, prophesying well for a technology that is more expensive but certainly a lot more effective and patient-friendly.

In fact, legendary hospitals such as Memorial Sloan Kettering Cancer Centre in New York are chasing up with RGCI in a few robotic surgeries. RGCI surgeons have used the robot to remove the bladder and reconstruct the urinary route. The long arms of the android have accomplished another complex surgery called RPLND which removes abdominal lymph nodes to treat testicular cancer and also finds its stage. With such surgeries, RGCI stands tall in the Ivy League of hospitals such as Mt Sinai Medical Centre.

However, RGCI is the least priced in cancer treatment today in the country in the private sector. “It’s an expensive surgery. But RGCI, fortunately, doesn’t fleece you. They have their rates and they are on the table,” says the General. Even though the CGHS has covered the bulk of his expenses, he has had to chip in which is disconcerting for a retired man like him. However, what he remembers most fondly is the friendly faces of the surgeons and nurses around him. “Half the battle is won in the mind,” says the soldier. “Your surgeon is the key man. If he radiates confidence in his behaviour and approach, you are already half way through. But if he is indifferent, you have started losing the battle. Everyone indulged me, perhaps because I came on the CEO’s recommendation. But I saw they were responsive and pleasant with the other patients as well.”

The expertise of a surgeon’s brain is utilised by the robotic arms, says Dr Rawal. A surgeon’s heart may be a different story though. As the number of patients opting for this ground-breaking mode of surgery, the robot needs to spread its arms. OT Supervisor CP Gupta proudly says a modular OT to house the robot is ready and being utilised. Meanwhile, nearly 11 months after the surgery, General Lakhera comes for a quarterly review. His PSA levels stand at sub 1 which is how they should be, his surgeon assures him. But he will tap his patient’s body for some time to ensure that all doors to his carcinoma have been sealed and sutured well. The General is happy to have gone back to his walks, reading and meeting friends. He is happy to have been the centrepiece of a music composition that can aptly be called heavy metal.
Slowly, I learn about the importance of powerlessness. I experience it in my own life and I live with it in my work. The secret is not to be afraid of it – not to run away. The dying know we are not God. All they ask is that we do not desert them.

Sheila Cassidy
Sharing the Darkness

Body and mind, cancer robs you of everything. It swallows your days, nights, schedules, relationships, moods – nothing is as it was. As a caregiver I want to fake my smile so that my husband can’t see how bad it is for me. But how long can you fake it when the reality of a lost job, depleting resources and looming hopelessness stares you in the face? When you know you have young children to educate and ailing elders in the family to look after and you know you can’t work because the entire domestic edifice rests on your succumbing shoulders? I feel like running away sometimes but I cannot do so...”

Running away isn’t the way of the courageous. But my visits to Mrs Sharma, wife of Naveen Sharma, have reinforced my belief that she is a braveheart. I have seen her fear transform, imperceptibly, into strength since her husband had a laryngectomy in 2010. Cancer has extracted its usual price from everyone in the family. She has held herself together in irremediable circumstance. For Mr Sharma, medicine can only serve as a palliative.

Mrs Sharma has spoken to me about his thyroid issue, his phobia of going out alone, of not being able to do anything for a living... Wandering the nights on the internet before drifting into sleeping in the small hours of the day is his only movement – and a part of his new normal. I, sometimes, wonder whether it is indeed normal to lose voice and job together.

We – a doctor, counsellor and a nurse – from the Palliative Care team go to their house every once a month in faraway Nangli Poona on GT Karnal Road since his surgery at a city hospital. A routine clinical check-up, including blood pressure and chest examination, is done at home. We leave him with nutritional supplements and painkillers – his shoulder hurts very much after the surgery and his body is increasingly sore from lack of exercise. We encourage him to get up to the rising sun, step out of the house at least for a morning walk, meet people, and look at the brighter side of life... Not always the easiest thing to do when one doesn’t know if and when recurrence will eclipse it again. Loss of voice can stifle the spirit too. Though he doesn’t explicitly object to our visits, I sense isolation – his from his family – and their vulnerability too. So, we continue.

As on May 2013, 116 patients were on the rolls with the Palliative and Home Care Department. Depending on factors such as the number of house-calls, the NCR areas marked for the day and the number of in-patients, we manage to visit three to five homes every day. These include those who have been treated...
outside RGC. As a counsellor, I have learnt that it takes immense grit to stay strong and positive in the middle of battle with death. You need someone to cushion your fall, to palliate you physically, emotionally and psychologically.

Our founders understood this implicitly. The hospital opened in July 1996 with a Home Care programme (which would later be called Palliative Care Department) in place. This made RGC a rare hospital that had such a facility. They felt strongly that every patient in palliative and terminal stages should be treated at home and free of cost since he is drained of all resources. This is true also for the family which needs someone to get across the wall that may have isolated the patient, and someone who can be an anchor to them too. Their lives have also been tossed up in a sudden, violent storm. Home care can be that anchor.

Interestingly, one of the meanings of palliation is ‘to cloak’. Beyond cure, cancer dons the cloak of pain, breathlessness, weight loss and other symptoms. The patient is treated for symptoms, so he can be as pain-free as possible and live quality life. But the meaning plays out in many poignant ways. Sometimes, families want to hide us from their world. They want to hide the disease from their patient, feigning she doesn’t know. “Don’t tell her please. Kal jaana hai, lekin batayenge to aaj hi chale jayenge,” they plead.

Not too long ago, we were visiting a young woman in her forties. Her family told us not to utter the C word in her presence. They hadn’t told her, they said. During the course of our conversation, it turned out that not only did she know she was ailing, she also knew it wouldn’t be a long haul. “My family thinks I don’t know. But I do and that’s why I keep my children away. I want to sever my attachments with my loved ones. I don’t want them sad when I am gone,” she said. It was a delicate moment. But was it fair to deny them her love while she was still there? We left her with that question.

Doctor Sahib, would you please come over for a little while? There is a family who has just lost their young boy...”

Dr YP Bhatia, Chief Administrator, was on the phone with the Chief of Head and Neck Surgical Oncology. He wanted the latter sitting with him for any technical explanations if the need arose. Cancer was then, as it is now, capricious and cunning ‘...as if teaching us how to survive.’ But this young boy – like many before him and after – succumbed. The family was distressed and furious, blaming their tragic loss on the hospital. Dr Bhatia sat with them... listening silently as they raged and cried in front of him. That’s all he did. It was a shared moment of grief. They got the space to pour out their anguish. Gradually, their resentment melted away. “They got up feeling lighter and returned without the ill-feeling natural in such a situation. Dr Bhatia’s wordless silence of that day had a lesson for all of us. Powerless before the inevitable sometimes, the least we can do is to heed to the family’s loss, stand with them in their hour of grief and let them know we understand,” says the surgeon.
There are some questions, however, we try finding answers to.

People like Mr Vijay Garg have told us to park half a kilometre away from his house or requested that the nurse does not come in uniform when we first started visiting his son Manu. Manu was treated at RGCI for leukemia 11 years ago. Sometimes, we have been told we would be picked up lest the RGCI Home Care van leaves its footprint in the neighbourhood.

Ten-year-old son Manu came to us in 2001. Two years later, he was already on maintenance chemo and doing well. But complications without definite causative links led to a debilitating neurology problem. Manu has been bed-ridden since 2003. We have been visiting him since and seen a young boy grow into a man – but who barely moves a hand and can only gurgle out some sounds. His confinement serves to remind how precious free will and freedom are.

“I was wary to begin with,” says Mr Garg. “My daughter was about to be married. I didn’t want her life affected by people who knew nothing about cancer. More than that, it was tough to answer a hundred questions and stand up to those pitying eyes. ‘Woh bechara’ – I couldn’t stand to hear those words. So I preferred to cover up… But the home care team from RGCI has stood by us. The big advantage is psychological, especially for my wife and mother who feel a doctor comes to see our child on a regular basis. Manu is a big 22-year-old now and impossible to carry. To know that someone is scheduled to come home and look at him, check for his blood pressure, feel his chest and stomach, advise us on what to do with his constipation, how to look after his bed sores is hugely relieving. Ten years of unrelenting work can break you… Everyone in our neighbourhood now knows about Manu. But we cannot ever forget the hospital support at the most critical time. Earlier Dr Rajni Mutneja and psychotherapist Anita Kumari, and now Dr Veena Chugh, have been very considerate. We have called them at odd hours when Manu has persistent fever or throws up in the middle of the night. They’ve been gracious with their time and advice.”

It is easier to rationalise ironies. But the suddenness of an end is hard to explain. I have often received a call from a patient’s family to visit them. We see her looking as well as she can. By the evening the story is over. At other times, people have slammed their doors on our faces saying they don’t need the service. They are angry, very angry with us.

I suppose despair makes the best of us aggressive in a sad sort of way. They are, perhaps, more helplessness, powerless against the inevitable, and angry that their doctor, who they believed to be God, had failed them. He would have told them in their interest that the hospital was no longer the best place for their loved one. The cost of the ventilator per day runs into several thousands. That it was pointless to poke needles and bind her in tubes and continue to pay a huge price for it. That she deserved a degree of freedom and dignity.

A doctor worth his curative powers aims only to make well his patient in all ways available to him. But I do believe that cure isn’t housed in medicine alone. It is perhaps the triad of doctor, patient and a higher dynamic that heals. The disease may recur but the doctor still takes a shot at treating if there is even a small possibility. Yet the patient may slip into the palliative phase. With the inevitable terminal phase on the cards, the doctor must know dawa must give way to dua. I have seen people adamant about removing their patient from the hospital. I have also seen the doctor trying his best to persuade them and eventually giving in, for, sometimes, he too is driven by forces beyond his control. An oncologist is not your average doctor. He starts as a healer and becomes counsellor, ally and friend over a period of time. The disease that breaks individuals also builds bridges between families and doctors. Palliative and Home Care service takes this bridge all the way to the patient’s home.

Lily Masih left RGCI after her treatment for cancer of the gall bladder that had spread to the liver. A couple of weeks, perhaps, or less before it would be over – her family was told.

“The doctor has a responsibility. As a professional he must gauge how much the patient wants to know; how much she already knows; and correct misconceptions, if any. If the patient is asking for more, the doctor-counsellor must learn to respond in a manner that gives them the information along with keeping hope alive. Else, the family will hold it in their hearts for the rest of their lives,” says Harmala Gupta, founder of Cancer Sahyog.

“The doctor cannot say that he gives the patient no more than three months even if he believes it. It is brutal, and it may not even be true.”

Barring the stray incident, we are learning – as most of us have indeed learnt – that breaking the ‘bad news’ is akin to ministering a bitter pill. It needs a sweet coating to make the swallowing easy, a searching inquiry than a decree and holding out the promise of doing what needs be done. Else, as someone’s rightly says, communication can be like tumour – benign or malignant, the bad effects of which may metastasise to the family. As a counsellor, I feel the process of palliation begins in the very first encounter between a patient and the hospital. Its forms may change – from diagnosis and actual medicine to emotional support, active listening to considerate speech. Sometimes, the doctor may be called upon to palliate, or the nurse, and other times, the psychiatrist – just about anyone who is part of the hospital. But the spirit of palliation stays constant.

I remember we would visit Mrs Masih for her check-up and leave with her some antacids for symptomatic relief from dyspepsia; a cough syrup if she needed; protein, calcium and iron supplements and her dose of painkillers for very severe stomach pains. Returning home coupled with her own will power had done her much good. But there were days when she was sick. Yet, she would perk up the day we were scheduled to come. She would bathe, get dressed and wait eagerly. In those 30 minutes
we spent with her, the doctor would check for heartbeat and examine the chest. We had tea together. Her daughter-in-law Karuna would have a heart-to-heart with the doctor who often advised her on medical and other issues. That’s been the routine mostly since the doctors asked them to register with us in 2008. This June 24, 2013, we called her to wish her a very happy 74th birthday. I am so glad we could.

Palliative care is not restricted to end-stage disease though. It becomes necessary as soon as the disease is known to have become incurable. One out of 10 deaths in India is related to cancer. A large section of this big population dies of unmitigated pain. More than 70 per cent of all cancer patients in India need palliative treatment to relieve pain and other symptoms apart from psycho-social distress. And these numbers are only going to rise as cancer prolongs its own life and threatens us to the point of teaching us rudely how to live – and to die.

Morphine is known to cause addiction and severe constipation. “But it makes little sense to withhold morphine to a patient in agony only because morphine may become addictive,” says one of our senior clinicians. “As a doctor, my intent must only be the patient’s welfare. If a drug relieves the pain, I must use it so that my patient doesn’t go through agony.”

We have a pain management clinic at the hospital that takes care of the entire spectrum of pain – mild, moderate and chronic. We dispense morphine to our home care patients as well, and when possible, Duragesic patches which are several times more potent than morphine. Yet we cannot do enough. Time drags for a cancer patient and, sometimes, her family. Our monthly visit has, often, seemed like a quarterly one to some of them. But we try. While changing catheters, we try changing the air around the house. Listening to a patient’s chest, we make an effort to put an ear to his heart. As we try palliating the body, we also endeavour to heal the mind.

One of our senior-most consultants Dr KK Pandey had once said, “Philosophers and sages told us there is something called moksha or nirvana. Not many know what it is. But they said – belittle death, because there is something beyond you that doesn’t die. They spoke of a centre, Kashi, where one would die happy. A centre like RGCI must endeavour to be such a place.”

FROM A COUNSELLOR’S DIARY

Of the patients in RGCI, the largest number of men suffer from cancers of the head and neck. Breast cancer afflicts the maximum number of women patients. This is followed by cancers of the lung and prostate in men and cervix and ovaries in women.

“Y ou get your car serviced even when it is running well. Why? You don’t want to be stranded in the middle of nowhere and want your vehicle to be trouble free. If only we could be as kind to our bodies! Unfortunately India neither has a robust screening and early cancer detection practice nor facility. No insurance company pays for it either. The fact is 10 lakh new cases come up every year. Over 70 per cent cases in India are detected late and a majority which comes for treatment to RGCI belongs to this category,” says a senior surgeon at the hospital.

Oddly enough, pap smear, mammogram, sputum and oral cavity examination and PSA are tests that can screen common cancers such as of the cervix, breast, head and neck and colo-rectal areas. In fact, preventive vaccines for cervical cancer are already available in the market. “But the most important thing,” says Head of Medical Oncology Dr DC Doval “is awareness so that people submit more easily to detection and prevention.”

It was with primarily this objective that the Department of Preventive Oncology was founded in 2008. Having commiserated with the severe physical and emotional trauma besides the enormous financial strain that cancer causes to not just one individual but an entire family, the department was only a logical next step in the evolution of RGCI.

“We mostly do opportunistic screening for common cancers at highly subsidised rates. A daughter who accompanies her mother with breast cancer is encouraged to do a mammogram. But we also work with the community as part of our outreach work,” says Dr Doval.

Spearheaded by a small team of ENT specialist Dr Jaigopal Sharma, gynaecologist Dr Indu Aggarwal, health educator and staff nurse, the department focuses primarily on creating awareness among the people about the need to screen periodically for early detection. Serving this mandate, it collaborates with the NCT of Delhi to conduct weekly screening through community-based detection camps in Gender Resource Centres free of cost. It also organises training programmes for health workers on prevention and early detection.

Over 21,000 people have been screened between 2009 and 2012. Over 1500 cases have been detected as pre-cancerous and 136 as early cancers. Consequently, not only have 8 per cent lives been saved through screening, but the cost of treatment has also been reduced considerably for patients.
A nd if you, too, hear a voice within saying ‘you cannot speak?’ What do you do, then, to silence that voice and learn to speak again, when the means of speech itself, the larynx or voice box, has been removed?

You go to Satish Sahni who over a decade ago lost his voice to cancer of the throat. Patients of laryngeal cancer at RGCI routinely do so. They go to the man who understands why silence isn’t necessarily golden and knows what it means to not be able to communicate one’s emotions and needs to the world around. He offers them lessons in the art that returned his voice to him.

He is no doctor, nor does he hold a degree in speech therapy. But five days a week, he works like an ‘adjuvant’ therapist cum counsellor to patients of the surgical team.

In fact just a couple of decades ago in 1987, he was a wholesale businessman of bathroom accessories in Delhi’s Chawri Bazar who sat in his factory everyday monitoring his labour dipping raw materials in acid to give them that extra shine. A non-smoker, non-drinker, he brought home an honest day’s wage to his wife and two children. By 1999, swallowing had become exceedingly difficult and the voice, hoarse ostensibly because of acid fumes. All treatments were short-lived. The family’s insistence took him to Deen Dayal Upadhyaya Hospital where a biopsy confirmed laryngeal cancer.

By 1999, swallowing had become exceedingly difficult and the voice, hoarse ostensibly because of acid fumes. All treatments were short-lived. The family’s insistence took him to Deen Dayal Upadhyaya Hospital where a biopsy confirmed laryngeal cancer. The windpipe, originally joined to the larynx, was reconnected to the hole created in the neck. It enabled him to breathe directly through it – but not for too long.

In July 2000, Mr Sahni came to RGCI with a stage IV tumour in the larynx. It had choked his speech, food and drink. Dr Kapil Kumar performed a total laryngectomy to remove the entire larynx. The windpipe, originally joined to the larynx, was reconnected to the hole created in the neck. It meant he would bypass the throat, mouth and nose and breathe through the neck. Two months later, it meant 30 cycles of radiation which would leave the 41-year-old man weak, sexually dysfunctional, without hunger, with anger and enforced silence.

There were ways to break that silence.

“There are three kinds of voice replacements – voice prosthesis, electro-larynx, esophageal speech,” says Dr Kapil Kumar. “Thirteen years ago, the prosthesis wasn’t easily available and not many people had started using it. We, too, were not so well trained to place it in during the time of surgery. If I had to do this surgery today, I would have certainly recommended the prosthesis to Sahni Sahib, as I do to all my patients now.”

Back then, the surgeon told Mr Sahni about converting the belch into sound, or training for the esophageal voice. It was difficult to learn, time consuming and now rarely used by laryngectomees. Encouraged and aided by laryngologist and phonosurgeon Dr BM Abrol, he went to Japan for speech therapy in December 2000. On returning, he joined the Laryngectomee Club of India and found his teacher in Mr Premanand, the treasurer of the club and, also, a larynx cancer survivor.

Weeks of unrelenting disappointment and agony finally yielded the first sounds from a hushed voice box. “In two and a half months, I produced my first ‘Aa’,” smiles Mr Sahni, pausing to push air into the throat and push it back up to articulate speech sounds. “I started with small sounds, uttering letters, speaking words. Then, I started calling out to my children trying to raise the pitch. It was like being a child all over again, making difficult, awkward noises towards speaking.”

The new voice found its echo beyond Mr Sahni. Word spread about the man who was neither using a voice-prosthesis nor an external device like the electro-larynx. He started counselling people like Rohilla Khan who had undergone similar surgery. “Months of therapy later, the daughter of the lady from Afghanistan came to me and told me that her mother couldn’t even speak ‘Aa’ or ‘Aum’.” “But she can say ‘Allah’ (Allah), the girl said,” he recalls, smiling. Different sounds, same meaning, he quipped happily.

In 2006, Dr Dewan, whom he had met during his surgery, called Mr Sahni in response to his resume to help them counsel needy head and neck cancer patients. Since the last seven years, he walks from his house in Subhash Nagar to take bus no 984 from Mayapuri Chowk every day to counsel five to seven patients at RGCI.

“‘He is a very courageous man,” says Dr Dewan, admiring the therapist some of whose ‘students’ have begun to outdo their teacher. “He now trains our laryngectomy patients and prepares them for surgery. I just tell him – Sahni Sahib, please explain to them the surgery, show them your stoma, the hole in the neck, and tell them what they should expect. He gives 30 minutes to an hour to counsel each patient. As a medical man, he makes my job so much easier since there is someone like him to share responsibility.”

Mr Sahni is all praise for his clinicians and the hospital. “Main gate se MD sahib ke room tak – sweeper, ward boy doctor, nurse, har ko mujhe jaanta hai... money is important but it isn’t everything. I was, once, the owner of two factories. After the surgery, I had to shut them down. But God has opened more windows for me. This hospital is like family. Other hospitals call me when they need me but don’t acknowledge my work like RGCI does – yahan mujhe pyar aur samman dono mila hai.”

Thirteen years later, Mr Sahni likes to be footloose and fancy-free. His wife and he love to travel on the rail-road pass that gives him the advantage of substantial discounted fares while their children have settled down well in their respective lives. At home, he counsels and trains patients for free who come from Deen Dayal Upadhyaya Hospital, All India Institute of Medical Sciences, LNJP Hospital and Safdarjung Hospital. He knows that the diagnosis of cancer, especially laryngeal cancer, pushes people into lonely silences. He also knows how crucial it is, then, to find one’s voice at such times.
I
t’s been 16 years since Nandini Gupta
Pradhan has known whatever happens,
will be what is required. End of December
1996, the civil servant from Sikkim heard
the first murmurs of malignancy in her body. A
thin, hollow needle was inserted just under
the skin on her breast. The procedure – Fine Needle
Aspiration Cytology or FNAC – for which she
travelled from Sikkim to Delhi confirmed the
cancer. The surgeon at a city hospital advised
immediate operation. “I felt a little stiff, a little
bruised... as though there was a scar,” she tags
a post-op file in her mental cabinet.

There was a scar. Her right breast had been
removed through radical mastectomy –
excision of the breast, the muscles beneath
it and lymph nodes under the armpit. The
evident malignancy had been done away with.
But she did not know about the extent of its
spread – the PET-CT scan was still a few years
away. Fortunately, the scar was only skin deep.

“My husband was clear – gaining life was more
important than losing an organ. He and my
family were very supportive – and at the time,
that mattered a lot. I thought they would do
chemo. By the grace of god, the much loved Santosh Handa of Cancer
Sahyog. She just wafted into the room along
with a couple of other Sahyogis to cheer her
up. “There is nothing to worry. Look at us,
we have survived, and we are doing fine. You
will too, she said, and went on to tell me of
places where I could get a prosthesis. Now
I get better prosthesis from England. But at
that time, her spirited support gave me the
confidence to tide over,” smiles Mrs Pradhan.

Two rounds of chemo and a meticulous plan
of therapy written out by Dr Doval so she
could continue her next two chemo cycles at
home, Mrs Pradhan returned to the salubrious
Sikkim air. Happy reminiscences of a hospital
that treated her like a VIP would be her
emotional adjuvant therapy. And of two
wonderful, kind people who had walked with
her in this journey – Vaijanti Mala, the OPD
Coordinator, and Rita Kelly, a nurse then –
both ever willing to do, to help, to soothe.

Dr Doval became a friend who would extend
a personal touch along with personalised
therapy that he recommended to his patient.
Mrs Pradhan returned for the last two chemo
cycles after which Dr Doval recommended
Tamoxifen – a kind of smart bomb that targets
– CMF – would be given through saline
water. The side effects would be negligible.
It was active enough in combination to foil
microscopic tumours – ideal as adjuvant
therapy in breast cancer.

Only two decades ago, surgeons were
very skeptical of chemotherapists,
even antagonistic. The surgeon felt a
chemotherapist “delivered drugs in advanced
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was the envoy of a brave new regime at
RGCI where a sizeable number of women
who came with the disease had cancer of the
breast. With decades of experience in Medical
Oncology, he specialised in treating solid
tumours, particularly of the breast, lung and
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Overnight admission for the first eight-hour
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S
antosh Handa, the smiling
custom of cancer survival. She
lost a breast to the disease
in the late eighties when she was
working with the UPSC. Returning
to work, post radiation, with a
mutilated body felt humiliating.
From stuffing cotton pads which
were very uncomfortable, she moved
to a silicon prosthesis her sister-in-
law got from abroad. The obligation
to cloak her body in thick saris was
over. In 1996, she joined Cancer
Sahyog and began visiting patients at
RGCI among other hospitals. Training
at Tata Memorial to be an effective
Sahyogi, she saw for the first time
mastectomy patients returning
home with latex prosthesis – and
confidence. That led to setting up of
a prosthetics unit at AIIMS. “It was
so satisfying to see a lady complete
in body and the glow on her face
was the greatest reward,” recalls
the plucky woman. Dr YP Bhatia,
then MD at RGCI, not only set up
the prosthetics unit but also helped
organise the first ever Breast Cancer
Workshop and Training programme
in 2000. Several women, including
eminent trainers from TMH, Mumbai
and Mastectomies Association of
India, attended the highly successful
workshop guided by Dr DC Doval.

Today, breast prosthesis imported
from Canada and surgical brassieres
are given free of cost to every
mastectomy patient at RGCI, says
Seema Gulati of Cancer Sahyog. “Not
only are they very comfortable,
surgeons here highly recommended
them to patients of mastectomy.”
only cancer cells with abnormal molecules (absent in the normal cells) as against chemo which works like cluster-bombing. Her tumour had tested positive for an estrogen receptor and Tamoxifen would prevent relapse specifically in patients such as Mrs Pradhan.

“The malignant breast tissue is tested for ER (estrogen) or PR (progestosterone) receptors. If a woman tests positive for them, she is given the hormone treatment,” says Dr Doval. “If she tests positive for another receptor called Her-2-Neu, we target the cancer with Herceptin. But if a woman tests negative for a receptor, for instance, that specific hormone therapy will not work for her. This is personalised medicine. Even though the drug is more expensive, it works better, gives more life span and is likely to cure.”

Nine long years of remission followed before an incessant, exhausting cough shattered the silence in January 2006. Mrs Pradhan returned to RGCI and to Dr Doval who sent her for radiation therapy under Drs Tejinder Kataria and Sheh Rawat. “I was upset at the second recurrence,” she says, understating the event. “But Dr Kataria took me under her care. It turned out that she was, like me, a devotee of Sai Baba. She comforted me, personally planned my radiation therapy and gave me 21 fractions. That done, I started another round of chemotheraphy.”

In a run up to radiation and chemo, Dr Doval referred her to AIIMS for a PET scan that revealed a malignant comeback in the lungs. RGCI did not have a PET-CT machine at the time. Her scan went off smoothly, thanks to Dr Doval’s referral but she remembers patients had to wait for a month or so for their turn at the PET machine. The report told her how active the disease was.

“AIIMS gave me a hand-written report but we did not get any digital reports on a CD. RGCI at the time had already started giving images on CDs. I remember meeting Dr Jena in the MRI department, who gave all my reports on CDs. This came in very handy later,” she recalls.

The picture would, however, change this time round. Chemo sheared her hair away. But Dr Kataria gave her supplements for quick growth and she was happy to have got “some really nice hair in nine to 10 months.” Her doctors seemed like they had declared a full-fledged war on cancer and would shield their patient in all ways possible.

She started returning for regular check-ups. End of 2009, a bone and PET-CT scan picked up a small lesion at the head of the neck of the femur. Another FNAC… she did not want one. They had seen it in the scan three years ago as well. But Dr Doval and Dr Dewan decided to let it be. “Let us know if there is pain. Until then, we will watch.”

The acute pain in 2011 took her to Dr Akshay Tiwari, the orthopaedic surgeon. The PET scan suggested malignancy at the tip of the femur. Even though Dr Tiwari seemed inclined on an early surgery, he suggested a second opinion on the PET. They sought it from one of the finest doctors at AIIMS who recommended radiation and offered to give it immediately. “But I wanted to return to RGCI. This was my treating hospital and had been with me in this journey. He had a word with the doctors here and I received another radiation round of 12 fractions.”

End of 2012, however, Dr Tiwari asked her to make up her mind about surgery. She had metastasis of the bone and he gave her the choice of getting operated elsewhere. She chose RGCI yet again. It’s been over a year and she is fine.

I think I am psychologically attached to this place. I have had three relapses – and I have recovered every time. At all times, I have felt deeply that I am getting the treatment I should be getting. Now, in spite of some inconveniences, I don’t want to go anywhere else,” she smiles.

Intimacy with the hospital and to know it has made life whole again gives the patient the courage to be candid. There were times when both felt the institute had become too crowded. “Dr Doval is inundated with patients. I miss that special bond I enjoyed with him… But at the end of the day, when a young school teacher came looking for advice on cancer treatment, I sent her right away to him. We’ve been recommending the hospital to everyone.”

“I have requested my state government to empanel RGCI and they are already sending patients here. The doctors are kind and friendly – and that, I believe, half cures the patients. The support staff could, perhaps, be more considerate to their condition. But the sweet words of the doctors and goodness of the nurses more than makes up for it,” smiles Mr Pradhan.

It makes up for the ‘conspiracy of silence, of hopelessness and helplessness’ and heals scars which aren’t necessarily seen. Dr Tiwari has asked Mrs Pradhan to now hang up her walking stick. It’s been more than 16 years since she was operated for breast cancer. She’s been through the entire gamut of therapy – surgery, chemo, hormone treatment, radiation and yet another surgery. “But she is always smiling and very positive about the disease,” her doctors agree. “She’s got a caring husband. We’ve never seen her come alone or with anyone else,” they smile as they speak of a gutsy patient whose association with the institute is nearly as old as the latter.
To have cancer, go through recurrences and stay cheerful is a tall order. You cannot theorise about it. A person going through disease – cancer in this case – is not capable of thinking about anything but his body, so totally focussed is the mind on the illness. But the power that puts us to a trial also gives us the strength to go through it – that is my firm belief.

I came to RGCI in 2010 with a lump in my breast. My gynaecologist had earlier told me there was nothing to worry about – at my age the size of the breast may increase. But something kept nagging me. Self-check and some awareness helped me move towards making a diagnosis. The FNAC and some other reports confirmed the malignancy. At the time I was busy organising the Teej festivities along with other women in the apartment complex we live in Vaishali. I am the cultural convenor of our society. People got to know about the report and came to console me – some expressed shock, some pity and some others, understanding.

Uss waqt ek aansoon to zaroor gira. But I told myself I wouldn’t give in to tears. The very next day my husband and I landed up at the hospital. A doctor in my family recommended a surgeon to us. Besides, RGCI was a familiar place. Twelve years ago, Dr Shelley Hukku, Head of Radiation, had treated my sister for cancer of the tonsils. We were very happy with the outcome. In fact, he called up a senior and very experienced medical oncologist in Jaipur which is where my sister lived so her chemotherapy could be administered there. Fortunately, she has long outlived her prognosis and is as fine as she can be. My daughter’s mother-in-law came to the hospital with cancer of the bile duct. Even though she did not survive, RGCI it was for us.

The surgeon examined me and recommended a few investigations. The reports were out soon after and I was admitted instantly. The surgery happened on the third day and I was out of the hospital the next day. It all happened so fast that I had no time to think about my disease. No depression, weakness – nothing of the sort. I felt fine, refused the wheelchair and walked out on my two feet. A month flew past. And then came the visitors and came also their stories about recurrence and loss. That’s when the gravity of it hit me.

External help at such a time is crucial. I had got a surgeon who was a thorough gentleman. My husband was with me at all times. I have had a very good life with him and its memories returned to cheer me up. We have only one daughter who is married and away. Neither of us expected her to come and serve me. True strength has to come from within. As an initiated disciple in a spiritual lineage, I have leaned on the teachings of our Master. Why must I worry so much? I have lived my life, lived it well and done my duty. I am 65. So what if I get a recurrence? An old building will need some fixing, some repairing every now
kareng, kisi ko thoda sukh denge, tabhi sukh payenge. That is why coming to volunteer even when one is going through a rough patch is tremendously healing.

A survivor comes from the space of compassion. I know it can be intimidating for the patient and attendant to be in a hospital. They are frightened, and they don’t know. Small things like clear signage and an organised diagnostic facility go a long way. We would have welcomed a facilitator who could have got the billing done for us; the files made and do other sundry things for a charge. Now, at Cancer Sahyog, we try and fill this blank.

I was struck by grade one tumour. I have experienced my share of fear – and even now, sometimes, I feel anxious. I exercise regularly. I wear the compression sleeve to contain the edema in my arm at all times except when bathing and sleeping. As for feeling warm in the summers, I don’t pay attention to it anymore. In fact, the reason why I came to Sahyog two years ago was to take my mind off myself. Along the way, I realised how valuable the presence of a survivor is for a patient. Perhaps, the former does not have the right solutions or advice. But she is a friend who’s been to hell and back. She can listen and she can speak. And she can reach out equally much in silence with a warm, encouraging, knowing touch.

Indu Goswami

One might say philosophising is easy. But to live with cancer and battle its return is hard. I have to admit I haven’t realised the truth of these teachings - I am also only a seeker. So, I don’t always use this philosophy when counselling as a Sahyogi. You’ve got to empathise with the patient. Sometimes the only important thing is to listen to him. Other times, we are told that the patient doesn’t know about her disease. Then we don’t even talk about cancer. We don’t tell them about our own recurrence. Instead, it’s a chat about their achievements, interests, happier things. Some of them are unlettered. They may not understand the enormity of their situation. To see them cheerful and spreading that mood around makes me wonder if ignorance isn’t bliss indeed. For one, they aren’t obsessed with the disease. Apna vistaar jitna adhik

and then. I meditate on whether I am only the body. I was a child. I grew up. That body was lost but I remained. The ‘adolescent me’ had another body. That body passed on but I continued... There is no reason for me to not believe that I will not continue even when this body is gone.

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Teeep... Teeep...” Mr Navin Khanna calls out in short staccato notes to his avian friend Teepu. He is on one of his morning rounds of feeding hordes of wild crows. Each of them has a name – Bholi, Bhola, Jhingur and Panja – and they answer to it when the Crowman calls. Next to him sometimes, and sometimes behind, walks his wife Sunila keeping their dog Boozo on the leash.

Teepu glides in slicing through thin air, finds an unusual perch atop a car parked in one of the colony lanes, and proceeds to peck away at a sumptuous breakfast. Well-oiled, plump parathas made dutifully by Mrs Khanna sit next to some home-made curd, salty savories and soft cottage cheese once requisitioned from Faridabad when Delhi ran short... there hasn’t been a day in the past 40 years when she has missed making the special thali for her husband’s companions.

The Crowman of India has been much feted in the media since the first black crow responded lovingly to his ‘Kauvva, Kauvva’ in the early seventies. Even though she has unfailingly nurtured this love between man and bird, not many know the cook behind the cuisine. Mrs Khanna has been mostly conspicuous by her absence in the reports and videos on her husband.

In much the same manner, she has stood silently, strongly with her husband and looked after him since he was diagnosed with oral cancer in 2010. Seen little, heard even less, and working tirelessly, namelessly – she shares her vocation with most caregivers.

“I knew my husband needed to be operated upon. But my son was against the very idea of surgery. The entire family was on the one side opposing it and I was alone, on the other. I spoke to Dr Tapasvini – she is part of Dr AK Dewan’s team of surgeons. She took great pains to counsel us. When I told her of my dilemma, she said – you’ve spent your life being led. This time, just stand up and take your own decision. Later, she also convinced...
Not once was I made to feel guilty for not face softens at the mention of his clinician. That was all he said to me,” and Mr Khanna’s now confirmed – Dr Dewan said kindly and also that there was a long queue ahead of him. He returned to RGCI early 2011. “Hope it is wait for the surgery, the doctors told him and mental plaque as well. He couldn’t afford to government institute of Delhi removed the removal of his tooth at a premier jagah dhakke khaaye, takleef jheli Mein maan hi nahin raha tha ki mujhe cancer Khanna submitted to the surgery because, But it would take six months before Mr Mr Khanna may have been a denial for a short while. But his public admission of chewing tobacco leading to oral cancer set in motion a whole new campaign. The hospital had put him in touch with Dr Pankaj Chaturvedi of Tata Memorial Hospital. The noted head and neck cancer surgeon connected him to various media organisations and the Crowman was on his way to becoming the anti-tobacco icon of the country. News agencies such as Reuters, television channels of France, Russia and England and Pakistan’s The Dawn carried reports and photos of the Crowman. “But it wasn’t my crows that brought them to me. It was… a confession – Maine mana ki mein tambaku khata tha. My family was a somewhat amused that I had become the centre of so much media attention. Zinda haathi lakh ku, mara hua sawa lakh ku,” Mr Khanna laughs out loud.

He wrote to Delhi Chief Minister Sheila Dixit about his initiative against tobacco. After his story was aired on television, the Delhi government banned the sale of gutka with many other states following suit.

But it would take six months before Mr Khanna submitted to the surgery because, “Mein maan hi nahin raha tha ki mujhe cancer hai… I wanted a double confirmation. RGCI respected my wish and I was discharged after being admitted in August 2010. Kai jagah dhakke khaaye, takeleef jheli… the first biopsy had only partly verified the disease. In spite of more than one biopsy, results were still uncertain. But everyone who saw me, including my dentist, confirmed it clinically.”

The removal of his tooth at a premier government institute of Delhi removed the mental plaque as well. He couldn’t afford to wait for the surgery, the doctors told him and also that there was a long queue ahead of him. He returned to RGCI early 2011. “Hope it is now confirmed – Dr Dewan said kindly and that was all he said to me,” and Mr Khanna’s face softens at the mention of his clinician. “Not once was I made to feel guilty for not having listened earlier. I was operated immediately. The CEO, Mr Negi, came to see me when he heard the Crowman had been operated upon,” he beams. “It isn’t often that one hears of the CEO of a hospital visiting each and every ward along with his entire team. But he did – every day, every ward. Kisi ke liye bhi itne logon ko roz attend karna possible nahin hai. Till as long as I was in the hospital, he visited me every single day – and once when he couldn’t come, he sent someone to look me up. Ye bahut badi baat hai…”

Dr Tapasvini gave them that personal touch so crucial to healing, says Mrs Khanna remembering the surgeon fondly, “Whenever she saw us – whether in the OPD or in any other department, she would always smile and wave at us in recognition.” Hospitals can be very inhospitable and doctors, arrogant. But they were kind and caring – towards each of their patients. They never looked tired – always bright and breezy, much like the flowers overlooking Mr Khanna’s window as he recovered after the surgery. “I like to grow flowers at home. But I learnt the value of flowers while I was at the hospital. I would just gaze out at them for hours. In fact, I dreamt one night that the earth fresh and fragrant and the flowers were flying… such a beautiful dream,” Mrs Khanna’s eyes catch a moist moment from an aching past.

Perhaps, the dream foretold the recuperative powers of a caring hospital, of the patient moving towards wellness, back to his flying friends.

Mr Khanna may have been a denial for a short while. But his public admission of chewing tobacco leading to oral cancer set in motion a whole new campaign. The of Robert Fighter, Bugni and Jhumru – his late crow friends, and fills his notebooks with fascinating accounts of crow-behaviour besides making regular trips to RGCI for his reviews.

But whatever else he may do, he belongs, heart and soul, to his birds. And it is his mother’s song that hums in his head in spite of his poor hearing as he walks to the park every morning to convene with them. ‘Kanwan de ghar taalayan, dera Magguwal’, he goes. Crows make their homes in trees but spend their buddy hours in a town called Magguwal. The Crowman’s dera too is with his crows – on the terrace, in the lanes, on the police check-post… Birds of a feather, indeed!
1981

**September:** Cancer Screening Centre started at St Stephen’s Hospital, Delhi, with a mobile van.

1983

KK Mehta and associates approach NDMC which grants them a place on Babar Road for the Indian Cancer Society Detection Centre.

1987

**September:** After retiring from Siemens India, Mehta Sahib starts the Delhi branch of the Indian Cancer Society headquartered in Bombay under Dr DJ Jussawala. The branch takes off with the screening centre at St Stephen’s Hospital.

Mehta Sahib moves the idea of starting a full-fledged cancer hospital.

1989

The idea to start a cancer treatment centre is conceived by a few dedicated individuals. Mehta Sahib is the main moving spirit.

The Rotary International and then Union Health Minister Dr Karan Singh support the idea. Dr Singh donates Rs 50 lakh towards setting up of the Institute Rotary Cancer Hospital on AIIMS premises. Late Mayor of Delhi Lala Hansraj Gupta, late Mr VS Ahuja and Rotary International Director ML Manchanda bless the project. Rotary North India also contributes Rs 50 lakh.

Mehta Sahib meets Lt-Governor of Delhi AVM HKL Kapur for land.

Mehta Sahib approaches Chairman of the Indian Oil Corporation late Mr SL Khosla for funds.

1990

**March:** 2 acres of land allotted in Rohini, Sector 5, to establish the cancer institute and research centre.

**November:** Another plot of 2331 sq. m. is allotted.

1991

**October:** A week-long Bhagwat Purana Yagya by Ramesh Ojha is organised on the Red Fort lawns to raise funds for the hospital. Few lakhs collected at the end of the Yagya.

1992

**April:** Foundation stone of Rajiv Gandhi Cancer Institute and Research Centre is laid by then Home Minister SB Chavan.

**July:** Construction of RGCI and RC begins.

**October:** Musical functions held by eminent sarod player Amjad Ali Khan, Anup Jalota and Ghulam Ali to garner more funds. About Rs 1 crore is collected through these ventures but still fall short for a cancer centre.

1994

**December:** A separate Indraprastha Cancer Society is formed to manage the affairs of RGCI.
1994–95
The Bombay and Delhi branches of the Indian Cancer Society divide assets and liabilities following the aspiration of the latter to build a cancer hospital. Dr Jussawala blesses the project and the Indraprastha Cancer Society is registered with 10 founder-members: Late Mr SL Khosla, ACM OP Mehra (retired), AVM HKL Kapur, Mr Madan Agarwal, Mr RN Bansal, Mr KK Mehta, late Mr VP Mehta, late Mr VP Lama, Mr OP Nayar and Dr KV Swaminathan.

Mehta Sahib meets MD of HDFC Bank Renu Karnad who sanctions 2 crore rupees as loan. Mehta Sahib stands personal surety for its repayment. Mr D N Sondhi enables a loan of Rs 12 crore from the Oriental Bank of Commerce.

1996
April: Havan organised on the occasion of the completion of the building of the institute.

July: Soft opening of the institute on 1st July by Mrs Sonia Gandhi.

August: Then President of India Dr SD Sharma formally inaugurates the fully furnished 152-bed institute as a project of the Indraprastha Cancer Society.

1999
The concept of Multi-speciality Clinics adopted in keeping with the international practice in reputed cancer hospitals across the world.

2000
November: First international conference RGCON on ovarian cancer. The convention continues till now, every year with a new organ-based theme.

2001
RGCI gets the Greentech Environmental Award 1999 and Golden Peacock Award for Environmental Excellence 2000.

2002
March: Four-bed BMT unit is inaugurated by Dr APJ Abdul Kalam, then with ISRO.

The first state-of-the-art radiotherapy facility IMRT (Intensity-modulated Radiotherapy) comes to RGCI.

The institute gets ISO 9000 and ISO 14000 certification for quality and environment. It becomes the first among Delhi hospitals to get this certification.

2004
Third plot of land measuring 1.5 acres allotted. The need for expansion results in construction of a new wing in April, adjacent to the existing facility.

2005
Academic courses of DNB begin.

2007
The concept of Multi-speciality Clinics adopted in keeping with the international practice in reputed cancer hospitals across the world.

2008
January: PET CT machine – the backbone of cancer imaging – is installed.

May: Inauguration of new building by Lt-Governor Tejinder Khanna. OPDs, wards housed in new building.

2009
August: RGCI touches the figure of 1 lakh patients.

Cancer awareness drives Jagrookta Abhiyan; Department of Preventive Oncology begins.

2010
The institute acquires IGRT (Image-guided Radiotherapy) equipment, the next-generation LINAC.

October-November: Surgical and Medical ICUs renovated. Four more modular OTs added. Today, RGCI has eight OTs.

2011
February: The robot comes to RGCI. Dr Sudhir Rawal performs the first robotic surgery successfully.

April: NABL certification for labs

December: Rapid Arc, the new radiotherapy equipment is installed.

2012
More than 550 robotic surgeries take place at RGCI in two and a half years making it the hospital to have performed maximum such surgeries in the NCR region.

June: NABH certification for the hospital.

2013
May: Bio-repository inaugurated in the Pathology block.

June: TrueBeam, the most modern equipment installed in the Radio Therapy Department.

August: The Blood Bank is NABH accredited.

At present, the institute has 302 beds, including day care wards.
Governing Council

INDRAPRASTHA CANCER SOCIETY AND RESEARCH CENTRE

MR. RAKESH CHOPIRA
CHAIRPERSON

MRS. JYOTSNA GOVIL
VICE-CHAIRPERSON

MR. PRAMOD MAHESHWARI
HONY. SECRETARY

MR. OP NAYAR
HONY. TREASURER

MR. KK MEHTA
PRINCIPAL ADVISOR

Governing Council

MR. MADAN AGARWAL
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MR. RN BANSAL
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ACM OP MEHRA
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MR. LALIT BHASIN
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MR. B SWARUP
MEMBER

DR. SUNIL KHETRAPAL
MEMBER

REPRESENTATIVE OF LG:
DR. NV KAMATH
(DIRECTOR OF HEALTH SERVICES)
MEMBER
And if you are responsive and receptive to the world, what happens then? You become diaphanous, so fine internally that the body ceases to be a separator. What happens to the other happens to you. Such permeability is empathy that can move the flesh, says Dr Larry Dossey. It has the power to change bodies, this loving care recognised as a valuable element in healing – and the bedrock of a cancer hospital.

The founders of the Rajiv Gandhi Cancer Institute embraced their collective pain and ‘burnt it as fuel for their journey’ that started with a dream and transformed into the reality that is RGCI. In time it has become one of the finest facilities in cancer care in the country. It is a place where suffering comes with an entire retinue – physical pain, emotional trauma, financial distress, psychological disability. But over a period, one has seen the healing hands of RGCI far exceeding this entourage. It isn’t the cancer confined to the body alone that its people strive to cure. It is the felt anguish of a heart, of a family, of friends that also resonates with them. Their multi-modality, then, doesn’t stop at advances in surgery, medicine and radiation. It includes an ever willing ear, a shoulder to lean on, a kind word spoken, a small help given, a nod of understanding, a smile, a sweet, an open door... and wisdom that theirs will not be a saga of despair and dirge, unstoppable as these are in a cancer hospital.

When the journey of the book started about a year ago, I believed I knew what empathy meant. But words unravel new meanings with time. Between then and now, one has spoken to founders, clinicians, nurses, administrators, inmates and patients who have lovingly and patiently un-spoiled their memories, allowing the life essence of RGCI to emerge. I realise today that essence is empathy. To that life-affirming principle I offer my gratitude.

I owe this realisation to many. To the security guard at the entrance who always smiled at me in recognition; to Purushottam ji for a helping hand even though eyebrow deep in work; to Amita Gupta for initiating me into the fascinating world of nuclear medicine; to Rejji John of the MRI department for showing me how some legacies are always state-of-the-art; to Anita Kumari and Dr Veena Chugh for lending special insights into home care and palliation; to Pankaj Verma and Gunjan Kapoor who walked me through the playroom in the paediatric ward and introduced me to the children and their parents; to Seema Gulati who cheerfully tutored me on the work of Cancer Sahyog; to Amit Malik for nurturing lunches and refreshing cups of tea; and to Rahul Gupta, Sachendra Bajpai, Mrs CK Chhabra, Dr Jaigopal Sharma and Dr Indu Aggarwal. I am indebted to Dr Dewan for reposing trust in a project so dear to him, for holding it ever so lightly, and always rescuing me when I floundered. To Mansi Bajaj – I cannot thank her enough – I am grateful for simply, strongly and quietly holding my hand through the course of this book.

And the course of this book would not be complete without a few lessons on the patients, some of whom are survivors and supporters today. They put up with all the intrusive meetings, and answered questions they may have found tedious to answer. They uphold within our minds the ideal of steadfastness and courage; the hubris of man’s belief in his immortality is far more moving than the despair wrought by a malefic disease!

In writing these pages one feels like having merely scratched the surface. But the exercise has also brought recognition of a larger, mysterious web of life which connects us all. And to that web we say in greeting: hello!
NABH Accreditation for RGCI and RC
NABL Accreditation for Laboratory
NABH Accreditation for Blood Bank
BSI UKAS Quality Management 003
Environmental Management System ISO 14001:2003
Golden Peacock Environment Management Award