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Foreword

'Walk into a classroom today, and you'll find students who are intelligent, opinionated, and, at first glance, utterly distracted. They are surrounded by notifications, expectations, and comparisons. Many are proud, not in an arrogant way, but in a quiet, self-preserving way. It makes it hard for them to ask for help, even when they desperately need it.

They have to deal with all the perils of social media, the comparison, the noise, the pressure to perform, to post, to prove. They hear of peers with lighter schedules, easier courses, more free time, and wonder if they alone are struggling. Often, they don't know who to tell. At home, their parents are likely juggling demanding jobs. There may be less time, less conversation, fewer soft landings after hard days.

A student once told me, "I used to feel sure of myself in school. Now I feel like I'm forgetting who I was." She was talking about academics.

So, what kind of teacher can we be?

Perhaps, one who understands. One who trusts. One who does not patronize or insult.

Being a good teacher today is not about having all the answers. It is about evolving alongside our students. It is about recognizing that we're no longer the sole source of knowledge in the room. They have their own material, their own notes, their own networks. What they often lack is someone who can help them make sense of it all.

And yet, we often find ourselves speaking different languages. There is poor communication, not because of lack of intent, but because each is caught in their own context. Teachers expect discipline, engagement, eye contact. Students expect relevance, respect, and a listening ear. To bridge that gap, we must learn where the other is coming from.

Today's students are not asking us to be perfect. They are asking us to be present. They are not waiting for immaculate lesson plans or elaborate lectures. They are waiting for someone who will listen, guide gently, and walk with them for a little while.

That, perhaps, is the kind of teacher they are quietly hoping for.'

Revathy's beautiful piece on teaching in the current era is actually quite timeless. Written on her blog a while earlier, it resonated so deeply with our theme on Teachers in this edition of the Quarterly Digest that we knew that we had found our Foreword instantly!

This edition of the Digest has some extraordinary Stories that Matter shared by our beloved Dr Banavali, in a Director's Corner in which he quotes Mahatma Gandhi, Sherlock Holmes and Steve Jobs, while also adding some equally profound quotes of his own. The teacher extraordinaire Dr Rajiv Sarin takes us behind the scenes of the Cancer Genetics Clinic, offering a firsthand account of its evolution, while we travel to the easternmost aspect of the TMC 'Unit'verse to gain an insight into the foundation and functioning of BBCI Guwahati. And do not miss the Good News Bulletin, guaranteed to bring a smile on your face!

There is something extraordinarily powerful and enriching both in the act of teaching and being taught. It touches us in ways that are deeply personal and transformative. It is no wonder then, that when we invited students and faculty to write about teaching, heartfelt and deeply touching articles poured in. Education is one of the three pillars of TMC along with service and research, and the content of the Doctors' Lounge reaffirms why it is not just a pillar but indeed the very bedrock of our institution's legacy.

Gurur Brahma, Gurur Vishnu, Gurur Devo Maheshwaraha,

Gurur Sakshat Parabrahma, Tasmai Shree Gurave Namaha

Acknowledgements

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CONTENTS

Director's Corner

Dr. Shripad Banavali
Director, Academics
Tata Memorial Hospital

Some stories that stayed with me over the years .....

Having been associated with Tata Memorial Centre for the last 38 years, I have many stories to tell. However, let me start by telling some stories. Stories that matter; mainly that left a mark on me, but they may also be of some interest, especially to the young faculty and students.

Thinking out of the box:

After completing my MD in Internal Medicine from Lokmanya Tilak Municipal Medical College (Sion Hospital), I joined Tata Memorial Hospital (TMH) in the department of medical oncology as a resident on 01-08-1987. The moment I joined TMH, I could sense the difference between other medical college and TMH. Faculty at TMH treated residents as colleagues rather than residents. The most important influence was naturally Dr SH Advani, HOD of medical oncology. He always encouraged residents to think and to think out of the box. I will give just one example. At that time, the chemotherapy ward was on the 7th floor of Annexe Building, which currently holds the molecular pathology lab. Within 3 months of my joining, there was a patient of angio-immunoblastic lymphadenopathy (AILD) who was treated with the standard treatment available at that time of COP (cyclophosphamide, vincristine, and prednisolone) chemotherapy. The patient did not respond much after six cycles of COP. She was very symptomatic and admitted in the chemotherapy ward with pain, low counts and infection. She was told about the progressive nature of disease and that there was no further treatment available. She was so fed up with life that she tried to jump from the 7th Floor CT ward (there were no grills on the windows at that time), but was caught at the right moment by a ward boy. On reading about AILD, I could make out that the underlying pathophysiology was a defect in the T-suppressor cell function with over proliferation of the T-helper lymphocytes. At Sion hospital, I used to work under the guidance of haematologist Dr M B Agarwal and we used to treat many benign haematological conditions. We used to treat autoimmune haemolytic anaemia, which had a similar pathophysiology, with Danazol a modified androgen, which is known to restore suppressor T-cell function by correcting the immune imbalance. So, during our weekly Tuesday Grand Round discussion, I suggested treating this patient with Danazol. I was just a newly joined junior-most resident in the medical oncology department; the patient had already failed cytotoxic treatment; and I was suggesting

treating this patient with a non-cytotoxic drug. The entire department laughed at the idea and advised against it. Dr Advani looked at everyone and asked whether they had any other better treatment option to suggest. Everyone recommended that the patient should be sent home without any further treatment. But Dr Advani told to let me be allowed to treat the patient with Danazol. We started the patient on Danazol and within a few weeks, she achieved clinical remission and later was documented to be in long term full clinical and biopsy proven pathological remission. This was the first of my many publications from TMH as a resident (Banavali SD, et all; Cancer 613-615; 1989).

This taught me early in my training to think out of the box; to think that there is more to medicine than evidence-based medicine. Sometimes we have to create the evidence. I believe in the famous advice that was given by Steve Jobs on the occasion of Stanford University commencement ceremony in 2005: "Stay hungry, stay foolish". What it means is to remain constantly curious and driven for knowledge ("stay hungry") while simultaneously being open to risk, innovation, and thinking differently ("stay foolish"). This mind-set encourages you to pursue bold dreams, question the status quo, and take creative risks, even if others deem them unrealistic or even foolish, ultimately fostering growth and potentially leading to breakthrough success. It also taught me to always encourage juniors / students who had novel ideas!

There are many things that I learnt at TMH, and especially under Dr SH Advani's guidance. He would tell us to watch him treat patients: not to learn about "practising the science of medicine", but to learn about "practicing the art of medicine" - how he gave hope to patients; how he touched patients while talking to them. He never pointed the faults of residents or faculty in front of the patient or relatives. Once, many years back, I was seeing a child who had a second relapse of Acute Lymphoblastic Leukaemia (ALL) in his chamber. In those days, it was difficult to treat a first relapse of ALL and this child had developed a second relapse. I told the parents to take the child home and that we could not do anything more. Dr. Advani did not say anything in front of the parents. After the parents left, he asked me why I told the parents that we could not do anything. I told him that the child has second relapse. He told me, "So what? Maybe we cannot cure the child, but we can do so much more for the child: take care of his pain, take care of his fever, give him symptomatic treatment. Never tell patients or their relatives that we cannot do anything". This lesson has stayed with me always. He would always say, "If you can't give hope, you have no right to take away hope from the patients". Now you know why every patient diagnosed with cancer wants to see Dr. Advani at least once!

"You see but you don't observe"

"You see, but you do not observe" is a famous quote by Sherlock Holmes, a character created by Sir Arthur Conan Doyle, from the story "A Scandal in Bohemia". There is a fictional story that once Sherlock Holmes and Dr Watson go camping and pitch the tent under the skies. During the night, Holmes wakes his companion and says, look up at the stars and tell me what you deduce. Watson says: "I see millions of stars and even if a few of those are planets, it's quite likely there are some planets like earth; and if there are a few planets like earth out there, there might also be life". To this, Holmes replied: "Watson, you idiot. Somebody stole our tent. My dear Watson, you see but you don't observe".

In our daily practice, we are so busy trying to finish our work that we do many things at the spinal level. We see many things, but we do not observe! There is a difference between passively "seeing" with one's eyes and actively "observing" by focusing on details, connecting the dots, and deducing meaning from what we see. Let me give you an example. We used to see at least 1 to 2 cases of trilateral retinoblastoma (Rb in both eyes and later involvement of pineal gland) every year in TMH. However, since we had started treating children of retinoblastoma with chemotherapy, we had not seen any patient with trilateral retinoblastoma. I discussed this in our retinoblastoma clinic but left it at that. Nearly two to three years since I had noticed this, there was a publication from Dr. Carol Shields in USA, who published that chemo-reduction for retinoblastoma may prevent trilateral retinoblastoma (Shields et al. Arch Opthalmol 2001). We could have been the first to report this, but "we just saw, we did not observe". I do not know how many times we have failed to "observe" just in a hurry to get things done. So, my request to all my young friends is to start observing. This will make a difference, not only for you, but also for our patients. More discoveries in medicine have happened by serendipity than by actual research. Please always keep your eyes and mind open.

"Be the change you want to see":

The sentiment, attributed to Mahatma Gandhi, aligns with his philosophy of self-reflection and personal action as the catalyst for broader social change. It suggests that instead of complaining about the state of the world or waiting for others to fix problems, one must take initiative to embody the values and behaviours one wishes to see in the society.

On completing my MD in Internal Medicine and later 3 years of Residency in Medical Oncology at TMH, I went to USA to work in the lab on a project I had myself written. Our team was the first to isolate CD 34 positive stem cells from AML patients and work on them. However, my boss there, Dr. Harvey Priesler, told me to do clinical work before going back to India. Since there were very few trained paediatric oncologists in India at the time, I decided to be trained in Paediatric Oncology at the St. Jude's Children's Research Hospital (SJCRH), the Mecca of Paediatric Oncology. Unfortunately, they told me that they took only paediatricians for training. So, I did my American Boards in Paediatrics and then did my Fellowship in Paediatric Haematology-Oncology at the SJCRH in Memphis, TN, USA. There, children came from all across the world and all children were treated free of cost! ALSAC, the fund-raising unit of SJCRH, raised funds required not only for treating the children, but also for undertaking research in childhood cancers.

On coming back from SJCRH, when I started treating children at TMH, I came across many hurdles. We had to send back many children with curable cancers because of lack of funds, lack of accommodation in Mumbai, and even sometimes because the parents could not arrange for the blood and platelets required to treat aggressive childhood cancers, especially acute leukaemia! I requested permission to start a Foundation on the lines of ALSAC to raise funds and other help required for the management of childhood cancer patients. However, initially the administration thought that since DAE is giving us sufficient grants, it would not look good to ask for funds outside the DAE to treat patients. This thought process changed once Dr RA Badwe became the Director of TMC. He helped us a lot by allowing us to raise funds with responsibility and making sure that the funds were used judiciously. I was instrumental in starting two foundations: RuHI (Runners of Hope Initiative), a fund founded along with Dr Rohini Kelkar, the then head of Microbiology Department; and the ImPaCCT Foundation (Improving Paediatric Cancer Care and Treatment)

founded with my colleagues Dr Brijesh Arora & Ms. Shalini Jatia. Through both these foundations, we offer holistic help to the children taking treatment not only at TMH, but also at the other units of TMC. The aim is that "Every child with cancer should get at least one best chance at cure". We not only arrange for financial assistance, but also for accommodation, nutrition, education, entertainment, bereavement, etc. Through this Foundation, we also started monthly parent support group meetings in the auditorium to educate the parents regarding various aspects of childhood cancers and at the same time address their concerns. Since we can talk to the parents for just a few minutes in the OPDs, the meeting is like talking to them for an hour! 80-90 % of questions remain the same for all parents. Setting up of the Foundation not only helped paediatric patients taking treatment at TMH, but also many patients taking treatment at our other units. In fact, looking at the success of ImPaCCT Foundation, other DMGs have also started organising such support systems. Very importantly, because of "Save a Life" project started by ImPaCCT Foundation, nearly 100% of blood and platelets support required for patients in TMH is raised through voluntary donations (as against just 11% when we started). The ImPaCCT Foundation Model has now been replicated in many other paediatric cancer units across the country, which has helped thousands of children across the country. When we spoke with the children who came for follow up, most of them told us that they do not have fond memories of TMH. So, we renovated the paediatric ward and the OPD areas and made both of them really colourful; we have developed beautiful play areas in both these locations; all procedures are now done under anaesthesia; we have started celebrating birthdays of the children; we arrange outings for the children and their parents; and every year we do a flagship HOPE program which gives a lot of joy to the children. In short, we strive to give the children taking treatment at TMC, a "lifetime of beautiful memories"! Children and their families come with fear but lot of hope for treatment at the Tata Memorial Hospital. We try our best to cure and send them back with beautiful memories! So, if you want to change something, do not think that the institution will do it, or that the government will do it! No one else will make the change. Start creating the change yourself, however small may be the start! If you really want to do something good, you will receive a lot of help from all corners to accomplish it!

ImPaCCT Team during the early days

Reel hero can be a real-life hero too!

Let me tell you another story of Jaganbeer Jaggu, a four-year-old chirpy boy from Ludhiana, Punjab, who was diagnosed with Burkitt Lymphoma in October 2018. The disease was so aggressive that he also lost his eyesight at diagnosis and the local doctors told his parents that his only hope was to go to TMH for treatment. The child did not want to travel, but his parents told him that they are going to Mumbai to meet his favourite hero, Salman Khan! The child agreed to travel only because of this.

By the time he landed in Mumbai, the child was very sick. He was diagnosed to have Stage IV Burkitt lymphoma, which had spread to his liver, kidneys and brain (which had caused the blindness). The wish of the child reached Salman Khan and in spite of his busy schedule, he took out time on Sunday evening to come and meet Jaganbeer who

was admitted in the paediatric ward. By this time, the child had lost all his vision and though he met Salman, he could not see him! However, Salman really spent some quality time with Jaganbeer and promised him that if he fought the disease and got well, he will meet him again on another day.

In the hope of meeting his hero once again, Jaggu not only bravely fought his disease, but he used to also console his grieving parents that everything would be all right! Fighting multiple complications requiring intensive supportive care, Jaggu continued the very intensive treatment required for such an aggressive disease. With the efforts of doctors and nurses at TMH and support from his parents, Jaggu completed his treatment in May 2019, is doing well ever since, and is considered cured of his cancer. By the grace of God, he has also recovered some vision and can see near objects.

Just a few days before his follow up visit to TMH in December of 2023, Jaganbeer who was 9 years old by then, started requesting to not only meet his Hero, but this time also to see his Hero in person! We again sent Jaggu's request to Salman Khan to please fulfil his promise and meet Jaganbeer! In spite of his busy schedule, Salman once again immediately accepted the child's wish at a very short notice and met Jaggu at his residence on 1st Dec itself and also gave him lots of toys. The joy on the child's face was priceless! Salman has also helped our patients in the past without making a noise. That just goes on to show that some reel heroes can also be real life heroes! We have actually come across many of them who have supported our ImPaCCT Foundation over the years.

There are many more stories. However, this write-up has already become quite long. So maybe more stories at some other time. I will end by saying that we are blessed to be working in TMC. I can write volumes on how so many doors have just opened just by taking the name of TMH, not only in Mumbai and India, but also on foreign lands. This is all because of the sweat and hard work of our predecessors. It is our responsibility and duty to make sure that we maintain the good name of TMC and continue to generate the goodwill in society.

We are so obsessed with the sophisticated, costly machinery for diagnosing and treating patients that we have sometimes forget to use the priceless machinery given to us by God: viz. our sense organs: looking at our patients, touching them, hearing them out, and talking to them. And yes, we have completely forgotten to "stop and smell the roses". It is a request to start using our senses more. We owe it to our

patients. Please greet our security staff, our labour staff, our colleagues, if you meet them in the corridors of TMH or outside. They will be happy. Most of all enjoy what you are doing. It will not only reflect in your work, but the patients and their relatives will also notice it.

I will end on a philosophical note with a poem that I had written many years back about this "World of Relativity". I take this opportunity to thank you for all your help and cooperation received over the years that I worked at TMH in various capacities: as a resident, as a consultant, as the head of the department, as the Academic Director, and most importantly as a colleague. I hope to continue to be associated with TMH in the future also.

THIS WORLD OF RELATIVITY

I once asked the CREATOR,
What is this life about and what should be my goal?
Striving only for pleasures in this mortal world, or
Would finding solace in sorrows, make mine a perfect soul?

First, define for me HE said,
What are these 'sorrows' and what is this 'happiness' you are talking of?
For are not all the sorrows of yesterdays,
The very foundation of a bright future's pay-off?

Salt when applied to the wound,
HE went on, definitely causes pain;
But the same when used to cook,
Isn't pleasure the main aim?

A child's first crawl on the floor,
Is such a source of joy,
But a wounded man crawling on the same,
Brings water to many an eye.

They say that the Sun sets,
And that it again rises;
But isn't it the Earth which
Really moves around its own axis?

The night comes after the day, or
Whether the dawn follows the night?
The glass is half-empty, or does\
Calling it half-full 'sound' right?

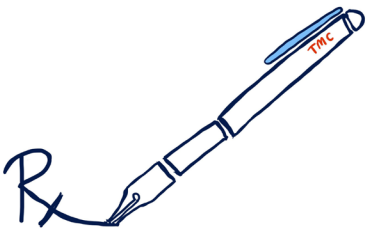
Thus, in this world of relativity, HE said,
For such examples, there is no dearth;
It is as comfortable for a fish to live under water,
As for human beings on Earth.

And my son, HE concluded …

Always remember the pendulum of the clock:
The further it ascends,
the lower it will have to descend.
And, the further it descends,
The higher again it will later ascend!

And as it is this to and fro movement of the pendulum,
Which keeps the time moving,
Let both the ups and downs in your life
Keep the journey of your life progressing.

For as a halt of the pendulum in any position,
Will surely stop the clock,
So also in life, striving only for happiness or finding solace only in sorrow,
Would indicate that one has reached life's last block!



Director's Corner

Dr. Bibhuti Borthakur
Director, BBCI

Greetings from Dr B Borooah Cancer Institute (BBCI), Guwahati. Though being the farthest from Mumbai, we are as connected within the close-knit TMC family as any other unit.

Founded in 1973, BBCI is named after Dr. Bhubaneswar Borooah, a highly revered physician of Assam who left an indelible mark in history as a committed, passionate physician and a fierce freedom fighter. In the early years after our independence, Dr. Borooah helped establish several institutions like Gauhati University, Assam Medical College, LGB Chest hospital, and Deaf and Dumb school, amongst others. These are now prominent landmarks in the educational and health landscape of Assam. He inspired thinkers and workers alike, urging them to engage in building our nation brick by brick.

Till a quarter century after independence, there was no facility for treatment of cancer in the entire northeast India. Once diagnosed with cancer, which would usually be at an advanced stage, one would be taken by relatives and friends to either CMC Vellore or Cancer Institute Madras for treatment. This would entail a harrowing travel of five days or more. We can well conclude that the large majority of these patients received palliative or supportive care, and returned home. Very few could receive definitive treatment, and a miniscule would complete treatment. Surviving cancer back then was a distant dream.

Tragically, cancer in the northeast was very common then, as it is today.

Inspired by the legacy of Dr. Bhubaneswar Borooah, prominent citizens in Guwahati mooted the idea about a cancer hospital. This led to the formation of a trust in his name and the creation of the first cancer hospital in the northeast, largely funded by the community. Resources were limited and interest among medical professionals in this specialty was scarce. The hospital struggled, but survived. Eventually, it was adopted by the Government of Assam and given the status of an autonomous institute. Soon, it was recognized by the ministry of H&FW as a Regional Cancer Centre. In subsequent decades, BBCI received financial aids from Department of Atomic Energy, Northeastern Council and the Assam Govt. The baby steps became larger strides, and BBCI earned the position of being the first

institute for comprehensive treatment, education and research in cancer in the region of seven sister states.

In 2017, BBCI was taken over by the Department of Atomic Energy as a unit of Tata Memorial Centre, which opened up new opportunities and supercharged the BBCI family. With a generous grant of resources from DAE, the overwhelming support from TMC and the warm welcome of a fraternity that celebrates shared progress, the strides of BBCI have become longer and steadier. Today one can witness numerous transformations happening in the modest BBCI campus – buildings, services, programs and events, courses and career opportunities, milestones and records. There is a renewed sense of confidence, trust and faith. Each day is a new dawn.

Each year, over 10,000 new patients come in, with more than 6,000 patients benefiting from the PMJAY program. With five radiotherapy machines, seven operation rooms and 25 daycare beds, functioning at full capacity, the daycare services continue through the night until dawn each day. Nine DMGs and twenty plus ancillary service units work in tandem. Relentless work, rewarding experience. The momentum gains.

During this time the Northeast has witnessed considerable transformation in every field, especially in healthcare. State-of-the-art cancer hospitals in public and private sectors have come up in nearly all districts of Assam, and all state capitals of the region. We take great pride in the fact that most of the medical faculty and the nursing and technical staff in these centres are alumni of the BBCI. Over the years we have helped several new institutions to come up, the latest being the State Cancer Institute of Arunachal Pradesh. Our outreach cancer programs and community research activities have touched every corner of the region. We are also witnessing a soaring interest amongst doctors to come, learn and work in BBCI. Those who join us wholeheartedly embrace the TMC philosophy of compassionate care with commitment, and return to enrich their own communities.

Even with so much development in healthcare infrastructure all across the region, the number of patients in the corridors of BBCI has not dipped – a testament to the trust that our patients place on us.

In the upcoming years, we will launch a haematolymphoid and pediatric oncology center, as well as a new outpatient department (OPD) block. Minimally Invasive Surgery, Reconstructions, Radiotherapy, Transplant science, Transfusion and Nuclear medicine, and a host of other services are set to have vertical and lateral growths.

The vision of the creators of Dr Bhubaneswar Borooah Cancer Institute which was to bring the best of cancer care to the doorsteps of the people of Northeast, is slowly being realized. We are very grateful to the TMC fraternity who have unquestioningly accepted this responsibility as their own, and to the DAE for hauling BBCI onto its shoulders. In our journey together there shall not remain any mile not covered.

Our reward will always be the trust of our patients. They will hold the bar for us to succeed, and raise it for us to strive.

Thank you for your warmth and wishes.

Inside Beat

Dr. Rajiv Sarin
OIC, Cancer Genetics Unit
Professor, Radiation Oncology

The Tata Doctor in the world of Genes

When I joined Tata Hospital as a Consultant Radiation Oncologist in 1996, cancer genetics was not even remotely in my thoughts. So, how did I get so involved in clinical, laboratory, and community cancer genetics? Its genesis is a mix of serendipity and opportunistic behaviour, and its sustenance I owe to patients and students. Returning after a 4-year stint at the Royal Marsden Hospital (RMH), London, and as a freshly minted assistant professor, I had to unlearn a few things and learn many new things. I was unlearning 'Bombay' to learn 'Mumbai', the new name of the city that got me back. I was unlearning the London way of driving and relearning the Mumbai way of driving a car. I was also unlearning the RMH way of finishing the clinic and ward rounds and relearning the TMH way. But there was one thing that I was unlearning very slowly, which got me into genetics. As the junior-most consultant in a busy unit of HoD, Dr. Shyam Srivastava, and Director TMC, Dr. Dinshaw, I was running around between buildings and floors, wherever my patients or students wanted me. In all this, what surprised me was that I was picking up many more patients with a significant family history of cancer than I had earlier seen at TMH. It didn't take time for me to realise - I had been too slow to unlearn the UK way of taking medical history. This serendipity got me drawn to cancer genetics.

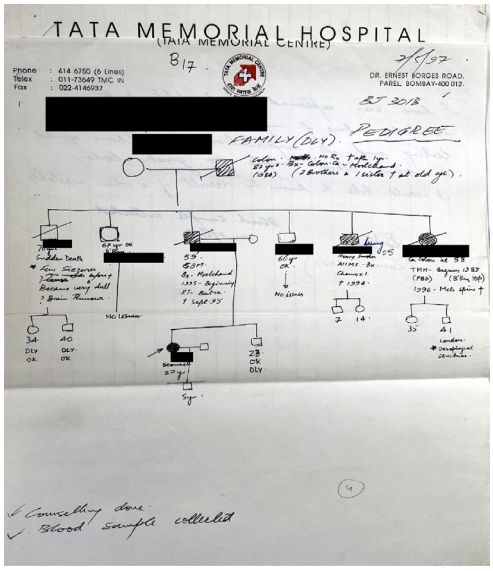


Fig 1: Pedigree with verbal autopsy 1997

At that time, the Human Genome Project was in its infancy, the BRCA1 and BRCA2 genes had just been found, and the phenotypic diversity of most cancer predisposition genes was unexplored. Gene hunters were on a rampage in the West, but not in the rest of the world, including India. New consultants scout for opportunities, and the prevailing TMH culture was not to curb their growth spurt, as long as the departmental work did not suffer. I had sensed this could be big, and would not let such an exciting, unclaimed research opportunity slip away. I started marking such patients in the busy OPDs and called them to my office during lunch hours to take a detailed personal and family history. I learnt how to draw a 3-4 generation labelled pedigree on any large enough piece of paper I could get - TMH Letter Head or the X-Ray Film cover yellow paper. I quickly learnt how to do a verbal autopsy and wrote down the full name and date of birth of close relatives who had cancer. I noted how, where, and by whom

the affected relatives had been treated (Figure 1). I had read fascinating accounts of major syndromes and genes being discovered in this fashion in Europe and the USA, where clinicians, molecular epidemiologists, basic scientists, and registries came together and shared data and DNA from interesting families. I reached out to oncologists, pathologists, and medical records officers at hospitals like Gangaram, AIIMS, PGI, and several RCCs, to fill the blanks in my otherwise well-documented families. There were no Ethics committees or MOUs back then in India. I did not know how to get their email IDs, so I started writing letters to the Medical Records officers and HoDs in these hospitals. Needless to say, I never got any reply. Soon, I stopped writing letters, but noting down details and doing verbal autopsies had become a habit that has stayed.

I wanted these rare families to keep coming back to me with more details and blood samples. I used to conclude the long session with the family by telling them that once we get more details about their family, and with our research (which was only in my dreams), and new scientific discoveries, we will know the cause of so many cancer cases in their family and find ways to prevent future cases. No doubt, a grand closure of a session, in reality, nothing really happened. It just added one more prized pedigree in my collection of papers pasted on a fat register, which I had boastfully called 'Cancer Genetics Registry'.

At times of self-doubt, there were no peers in clinical genetics to get feedback on where I was going wrong. It was easy for me to blame my lack of progress on the missing genetic testing labs in India and the academic research labs being preoccupied with basic research or polymorphism studies. I could never understand why Myriad Genetics in the USA was allowed to uphold its patent on BRCA genes and its testing to exploit its monopoly by charging an astronomical sum of 3000 US Dollars for BRCA testing. At that time, it was the only lab in the world doing comprehensive and reliable BRCA testing. The huge private database of germline variants it had collected through patient testing, allowed Myriad Genetics to interpret the pathogenicity of BRCA variants much better than other academic labs outside USA.

My hopes were rekindled when I made some molecular biologist friends at the adjoining Cancer Research Institute (CRI), located on the land where the Homi Bhabha Building stands today. On my handwritten, signed consent, I collected blood samples of patients and relatives from many rare families and took them to CRI. There were no ethics committees and no annual status reports to be submitted on what happened with these precious samples sitting in someone's deep freezer. I had realised that professional scientists would not, rather could not, move ahead without lots of samples of the type they want, project money, equipment, and a PhD student devoted to any new project. Tumour suppressor genes were quite intimidating due to their size, with different kinds of mutations that are spread over their entire length. 'New Gene Discovery' was an enormous undertaking. Our CRI did not even have an automated DNA sequencer. While I could share my excitement and ideas with my scientist friends, nothing really moved in the real sense. Dr Mittra was one person who always encouraged me and said, "Rajiv - the kind of genetics you do is good and makes sense - the rest of the reductionist molecular biology is going nowhere." Dr Shyam Agarwal who joined as 1st director of ACTREC became my intellectual guide in genetics.

But dealing with these families was becoming increasingly embarrassing. How to tell a desperate family every 6 months that next time we may be able to find something that could help them or their family. Their time was ticking, and mine was not starting. I did not know how to navigate through the vast, complex, rapidly growing, and intimidating literature on clinical and laboratory cancer genetics and genetic pathways. It dawned upon me that academically and professionally, my opportunistic foray into Cancer Genetics was simply weighing me down. To maintain academic sanity, and not to miss the coveted 'E' to 'F' promotion in 5-6 years, I started publishing systematic reviews on breast cancer or brain tumours (but not cancer genetics) in journals considered big in TMH in

those days - Lancet Oncology, Lancet Neurology, Nature Clinical Practice Oncology, etc. In my clinical world, things that I had initiated and established, like the the Brain Tumour Foundation (BTF), the Joint Neuro Oncology Meetings (JNOM), the Breast APBI and IMC Brachytherapy programme with Rajan Badwe, and the first randomised trial of Stereotactic Radiotherapy for Brain tumours (SCRT Trial) that I wrote with Rakesh Jalali were all doing well, thanks to outstanding colleagues who covered for me whenever I was lost in my world of genes.

The honeymoon period was over. Cancer genetics was limiting my output as an oncology researcher and teacher. Silently and schemingly, I started retreating from all aspects of Cancer Genetics, including my old and new families. During residency days, Tata doctors learn how to navigate through the labyrinthine Tata Hospital complex. They use this trick to good effect when we had to reach a place quickly, and also when, for any reason, we had to evade a senior or a patient, or a relative. My half-hearted attempts to evade families asking difficult questions somehow always failed. They were desperate to talk to the doctor who had once shown so much interest in them and their families, had actually listened to them, noted down minute details, and had given some sort of hope. I remember a breast cancer patient asking me, "Sir, last time you said you would tell us what to do for our daughter. We also brought her blood sample for your gene bank. My niece just died of ovarian cancer - the fourth person in our family. I am so worried for my daughter - please help. If you are very busy, can you send us to another doctor?". How could I, or for that matter any other doctor, help her daughter when there were no genetic testing labs in India, and suggesting a $3000 blood test was out of the question? These are uncomfortable and unsettling moments for doctors. I remember sitting expressionless on my big consultant's chair, feeling my own weight, and not knowing what to say. Many such unsettling experiences with families that I had come to know well started to affect me personally and my approach. The opportunistic researcher in me, craving for blood samples, DNA, DNA sequencing, scientific progress, and personal fame, gave way to the original Tata doctor in me - a breed that thinks and works hard to help unfortunate patients from across the country. That is what used to move Tata doctors then, and I can see this trait survives in so many of my younger colleagues, despite the increasing pressure to publish and become eminent.

This simple switch and becoming the good old Tata Doctor again lifted a huge weight off my chest. The frustration and nihilism of not making scientific progress were replaced by a new kind of enthusiasm - to do whatever we could

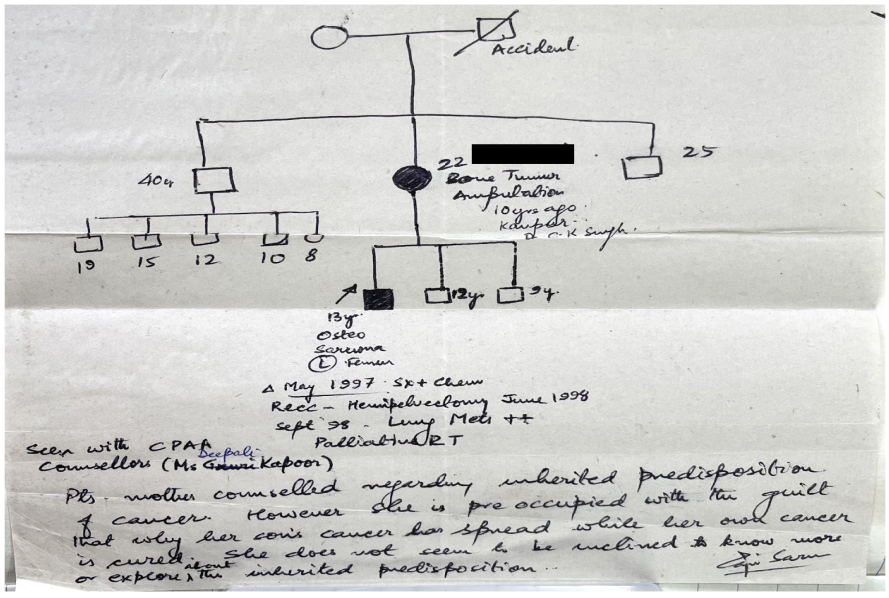


Fig 2: Survivor's guilt, 29.09.1998

to the best of our abilities for the sake of our patients. I started to see my old pedigrees in a different light. The survivor's guilt in this pedigree (Figure 2) I understood much later, which was initially clouded by my disappointment at this young mother's unwillingness to give her consent and blood sample, for me to publish the first ever Non-Caucasian Li-Fraumeni family in 1998.

I enrolled myself in my self-learning school, studying harder than I ever had for my MD or FRCR exams. I could never leave this school or get a degree, but I gained enormously. Slowly, I started understanding

and appreciating the nuances in clinical cancer genetics, molecular biology, laboratory genetics, genetic counselling, and its many ethical ramifications that no consent form can ever capture. I attended training workshops in clinical and molecular genetics in India and extended my USA trip for ASTRO 2003 to spend a month in a Cancer Genetics Clinic at the Huntsman Cancer Institute, Salt Lake City, UTAH. For the first time, I saw experienced Genetic Counsellors in action - as a vital bridge between patients, families, oncologists, and the genetics labs. They could simplify things and bring meaning to the technical jargon of a genetic test report. They were very kind to me, as they are to everyone, and taught me practical skills for interviewing,

Figure 3: With Genetic Counsellors, Saly Lake City, Utah, 2003

confidentiality, privacy, family record keeping, and genetic databases. Genetic test results could be life-changing. The most important thing I learnt from them was to identify and work around the vulnerabilities of people and safeguard them to the extent possible. They even took me on a trek to see the colours of fall (Figure 3). I never met them again, but I owe a great deal to these wonderful people. I came back with many ideas to improve our service and have maintained my respect and admiration for genetic counsellors.

In 2003, the TMC Cancer Genetics Clinic was officially notified, and I was appointed as 'Officer-In-Charge - Cancer Genetics Unit', a designation which I still carry with great pride. The challenge was to get a Cancer Genetic Counsellor for our clinic, when there were none. For many years, I managed with volunteers and project staff, whom I would train to draw pedigrees and listen to patients. One such volunteer, Neena Bhatnagar, turned out to be an excellent learner, listener, and empathetic. She is now the seniormost Cancer Genetic counsellor in the country. She worked with us for a few years as CGC Coordinator and Scientific Officer. Payal Manek was the first fully trained Genetic Counsellor (from Australia) who joined as permanent staff, and was later followed by Gouri, Vandana, Areeba, and Ravi. The OG, now scattered, still meets and fondly remembers the good old experiential TMH days. Over the next 10 years, we trained a few dozen Cancer Genetics Counsellors for a year or two before they left for the USA or joined the newly coming NGS labs like Strand and Medgenome. I had realised running a service without well-trained and adequate number of GCs is a disservice to our families. After many years in preparation, we could finally arrange enough philanthropic funds to start the first batch of 12 trainees in the TMC 1-year PG Diploma in Cancer Genetics & Counselling, whom I call my Gene Apostles (Figure 4). The 2nd batch, which will be starting soon, will now be supported by TMC.

Figure 4: My 12 Gene Apostles, 2024

Before the NGS labs came to India, Germline Genetic testing for cancer was done in few small research labs on small cohorts. The research testing was limited to BRCA1, BRCA2 or a few other genes, and without a system to formally report and disclose the results, genetic counselling, and cascade testing in the family. Even in the year 2012, this was the status in all the Asian countries, as

Figure 5: First Asian BRCA Consortium meeting, 2012

proposal I had submitted in 2003 as a full-time TMH Radiation Oncologist, doing a weekly Cancer Genetics Clinic in GJB, but the money finally came in 2007, when I had become a Clinician Scientist in ACTREC and had started a daily Cancer Genetics Clinic at TMH. While I had trained myself in wet lab work through workshops and extensive reading, to set up a lab, I needed a full-time PhD scientist. Pradnya Kowtal then joined me and worked hard to get it going. With Pradnya, few scientific assistants, PhD students (Nikhat, Moquit, Vasudha and Anuja) and many project JRFs (Figure 6), we started large-scale Sanger sequencing, MLPA,

Figure 7: Founder mutation community camps

we realised in the 1st Asian BRCA Consortium meeting (Figure 5)

In India, BRCA1/2 Sanger-based testing was first introduced by Reliance Lifescience about 20 years ago. However, their test was also beyond the reach of the vast majority of Indians. It was then one of the most expensive medical tests of any kind at R 50,000. So we had to have our own lab in TMC, which can do germline testing. As the cytogenetics and pathology labs in TMC had no plans to start germline testing, I set up a germline genetics research lab in 2007 in ACTREC through an ICMR Centre for Advanced Research (CAR) grant in Cancer Genetics and Genomics. This ICMR

Figure 6: The Cancer Genetics Lab members, 2010

and a few other techniques to look at 15 cancer predisposition genes.

Most cancer predisposing genes are big and code for proteins that have several thousand codons or amino acids, like the BRCA1 gene, which codes for 1863 amino acids. The mutations in these genes are spread across the gene. We started finding that certain mutations at a particular location in a gene are very common in unrelated families from the same community or region. We showed that these are founder mutations. Starting from a common ancestor, after 20, 30, or 50 generations, they are present in thousands of people from the same

community or region. Over a period of years, we have identified 25 recurrent or founder mutations in BRCA1, BRCA2, MLH1, MSH2, CHEK2 and a few other genes. We call them Konkanastha Brahmin mutation, CKP mutation, Maratha mutation, Mahar mutation, Mali mutation, Gupta mutation, Marwari / Jain / Gujarati / Bohra mutation, Yadav mutation, Khatri mutation, Sindhi mutation, Bengali mutation, Nepali mutation, Meiti mutation, Shia Momin mutation, Agri / Koli mutation etc. One day, when I was asking my GC to see if this family has Jain mutation, the patient asked "Sir, you know Jain Paav Bhaji and Jain Dharam. Will the BRCA mutation, which you say is Jain, follow Ahimsa?" We did several community camps to ascertain the population frequency of these mutations, but after the pandemic, we had to stop the community genetics project without reaching any conclusion (Figure 7)

For cases with very strong family history or syndromic features in whom Sanger / MLPA did not identify any mutation, we started doing in-house germline Whole Exome Sequencing. Ten years ago, doing in-house NGS was very exciting and a great learning experience for us. This research NGS experience came in handy when I started in-house germline NGS testing service, along with Pradnya, then Poonam Gera and Somya Srivastava. I was reluctant to get into this space because of the challenges in large-scale reporting, but ace clinicians and end users like Sudeep Gupta, Jaya Ghosh, and a few others persisted in their demand. Thankfully, I listened to them and we have not looked back. The support I got from the ACTREC and TMH leadership is something I wish everyone, in every hospital, should get. In the last 4 years, we have done over TEN thousand germline multigene NGS and a few hundred exome sequencing.

Very early in my genetics journey, I realised that wrong classification of a germline variant could have devastating consequences for the patient and any family member found to have the same variant misclassified as pathogenic or disease-causing. I remember the worried parents of a healthy little girl reported at an outside lab to be having the same RET gene 'mutation' as her mother, with Medullary Thyroid Cancer. The child was advised prophylactic thyroidectomy by her mother's HN Surgeon at TMH. Seeing the parents reluctance, they were sent to me for additional counselling. To my surprise, RET 'mutation' reported by this lab was not a cancer predisposition pathogenic variant, but an innocuous polymorphism that every 4th reader of this article would be harbouring. While this girl made a lucky escape some 15 years ago, I continue to see many such wrong reports from outside NGS labs, irrespective of their NABL or CAP-accreditation tags. It worries me how NGS labs are mushrooming all over India with poor regulations and oversight. It has made me realise that more than a high-throughput NGS machine finding a DNA variant and many bioinformatics pipelines and curated databases, careful human interpretation of the variant is still critical. I am not sure when AI will take over that role. I was fortunate to have honed my skills in variant interpretation and classification at a time when there was no ClinVar database (launched in 2013) or the ACMG-AMP germline variant interpretation guideline that came in 2015. Learning it the hard way by carefully examining the structure and function of the gene with the variant, the genotype-phenotype correlation, the personal and family history, and tumour features, gave me the much-needed confidence in variant interpretation and reporting. It comes in handy when the genomic databases and bioinformatic tools are unable to classify a novel variant or in classifying a variant with an ambiguous or conflicting interpretation of pathogenicity. It is particularly relevant now that we find so many novel or rare variants in the 2500+ germline NGS tests we do in-house every year. Through our annual Indian Cancer Genetics Conference and Workshops (ICGCW) that we started in 2013, we share with others what we have learnt about genes and how they affect lives and families, and what can be done to find them and counsel them.

Interacting with TWENTY THOUSAND FAMILIES that we have enrolled so far in our TMC Cancer Genetics Clinic has been very enriching. Each family, and each person in a family, is unique. The tears of joy, tears of sorrow, the sister act, the mother act, the brave act, the self-sacrifice act, the paternity issues, the dark secrets, the human aspirations, the human sexuality, and the range of dynamic emotions that I have seen very closely inside the four

walls of the Cancer Genetics Clinic have taught me life lessons. I have seen children as young as 10-year-olds being so sensible, reasonable, and thoughtful - they just need space, time, a degree of autonomy, and respect, like adults. On several occasions, the situation demanded that I had to act as a marriage counsellor, sex therapist, grief counsellor, and many such roles for which I am not trained. I remember my emotions when a young breast cancer survivor with a BRCA1 mutation, and her mother, waited for hours outside my office to first give me her Lagna Patrika (Marriage card) before going to Siddhi Vinayak temple. They felt that the marriage would not have happened if I had not counselled the groom's family, with whom they had not hidden anything. She is now a busy mother of 2 children and came last week for follow-up.

At TMC, we are obsessed with saving lives or easing the sufferings in the lives of our patients. This gives us joy and purpose. But the joy of helping a family to bring a new life to this world is very different. Some 15 years ago, a senior TMH staff approached me to help a young couple in her family who had recently lost their only daughter to a serious hereditary cardiac disease. They longed to have another child, provided prenatal testing could ensure the potentially fatal condition would not be passed on to their next child. I was doing only the cancer genes and not the KCNQ1 cardiac gene. Initially, I was reluctant, as it would have required me and my lab partner, Pradnya to study the gene, get special ethics approval, register our genetics clinic and lab under the PCPNDT Act, and achieve technical perfection so as not to miss the mutation in its heterozygous or homozygous form in the small amount of foetal DNA that we would get. But no other lab in India was doing it then. It was not feasible for the couple to go for a few months to a foreign country, where this test was possible. Finally, we did it! I was overjoyed when the family invited me to the First Birthday celebration of the chubby boy GATTU, whose DNA we had tested 6 months before he came out in this beautiful world to become part of a loving family. (Figure 8)

Figure 8: PCPNDT ACT registration of Cancer Genetics Lab and Genetics Clinic for GATTU!

Jervell and Lange Nielsen (JLN) syndrome: Rare autosomal recessive disorder. Deafness and prolonged QTc interval and sudden cardiac death (KCNQ1 Gene homozygyous mutation)

The gene journey I have taken is a testament to the ethos and medical culture of TMH that gave liberty to someone like me with no background, training, or qualifications in Cancer Genetics. I remember my Guru, Dr Ketayun Dinshaw, who allowed a new faculty like me to indulge in my fanciful world rather than pinning me down to implement at TMH the cutting-edge radiotherapy techniques that I had learnt at RMH. Many years later, when she was about to retire, after listening to my talk on genetics at a conference, she told me, "Rajiv, I am so envious of you. I wish I were younger and could start learning and doing all this." What took me nearly 3 decades, I hope will be a matter of a few years for my younger and more enthusiastic colleagues. Aided by powerful NGS technology, AI, and a large team of empathetic genetic counsellors, they would be better than I ever was in taming the rogue genes. I wish them luck.

The TMC Uni(t)verse

Strengthening Cancer Care, Research, and Training: The BBCI Perspective

Dr Kaberi Kakati
Professor, Head & Neck Surgical Oncology, BBCI

Introduction

From its humble beginnings as a vision of a voluntary trust to its present status as a unit of Tata Memorial Centre, Dr. Bhubaneswar Borooah Cancer Institute (BBCI) has remained steadfast in its mission : to provide quality cancer care, advance research, and extend hope to patients and families across Northeast India and beyond. Established in 1973, BBCI Guwahati, is a symbol of hope for thousands of cancer patients across Northeast India.

The idea of setting up a cancer hospital in Guwahati was first conceived in 1958 at a public meeting, as a tribute to Dr. Borooah's lifelong service to society. The initiative was spearheaded by the Dr. B. Borooah Cancer Society Trust by a few of the distinguished individuals from the land. In 1980, it was recognized as a Regional Cancer Centre by the Ministry of Health and Family Welfare, Government of India. The Institute officially became a Grant-in-Aid Institute under the DAE and a unit of Tata Memorial Centre on 27th November 2017.

Infrastructure and Facilities

Situated at Gopinath Nagar, Guwahati, Dr. Bhubaneswar Borooah Cancer

Institute (BBCI) is spread over a sprawling 14.2-acre campus (approximately 43 bighas). It currently functions as a 312-bedded hospital, catering to an average monthly footfall of approximately 25,000 patients. BBCI also provides accommodation and support facilities for patients and their families. A 60-bedded guest house, which houses the St. Jude's Centre, is dedicated to children undergoing treatment and their attendants.

In addition to the Outpatient Department (OPD) building—which includes OPD consultation rooms, the Onco-pathology Department, Blood Bank, and other allied services—BBCI is equipped with:

1. Linear Accelerators:
    - Linac A (3D-CRT, IMRT)
    - Linac B (3D-CRT)
    - Linac C (3D-CRT, IMRT, IGRT, SRS/SRT)
2. Phoenix Teletherapy Machine
3. Bhabhatron II Cobalt Teletherapy Unit
4. HDR Brachytherapy (Cobalt-based)
5. Gamma Camera for SPECT Imaging
6. PET-CT Scanner
7. Therapeutic Nuclear Medicine Unit
8. Bone Marrow Transplant (BMT) Ward
9. CT Simulator
10. Radiation Treatment Planning System

Additionally, the campus includes a Power Grid Capacity Development Centre, which also houses the BBCI College of Nursing and a DBT Centre for Molecular Biology and Cancer Research, contributing to the institute's growing research capabilities.

Research

Beyond patient care, BBCI is deeply committed to cancer research, contributing significantly to national and regional cancer studies. Established in February 2010, the DBT Centre for Molecular Biology and Cancer Research conducts cutting-edge research in molecular biology, genetics, and cancer biology, helping improve diagnosis, treatment, and prevention strategies. BBCI also contributes to both Population-Based and Hospital-Based Cancer Registries under the National Cancer Registry Programme of the Indian Council of Medical Research (ICMR). The Clinical Research Secretariat (CRS) is proactively working since 2024 and serves as the central contact point for all collaborative research projects within the institution. CDSCO and DHR registered Institutional Ethics Committee (IEC) was established to formalize and specify the Institution's commitment for promoting high scientific and ethical standards. As of 2024, a total of 13 Investigator-Initiated Trials are currently ongoing. Since 2019, the IEC has approved 350 research projects. The Institute is involved in multiple national and international research collaborations, focusing on many areas. To strengthen research and treatment capabilities, the institution has entered into several memoranda of understanding (MoUs) to collaborate with multiple organizations. A total of 58 MoUs are currently running.

Academics

The Institute has greatly expanded its academic courses over the years. In addition to DM courses in Medical Oncology and Oncopathology, and MCh courses in Surgical Oncology, Head and Neck Surgery and Gynaecological Oncology, it offers MD in Radiation Oncology, Post Basic Diploma in Oncology Nursing, PhD programmes of paramedical courses under Srimanta Sankaradeva University of Health Sciences (Guwahati), and the TMC-Merck Fellowship programme for African Doctors/ Nurses, among other programmes. Additionally, it started four

new Senior Fellowship Programme affiliated to Srimanta Sankaradeva University of Health Sciences and 3-year Competency Based Fellowship in Oncology. Plans are underway to start BSc in Nuclear Medicine Technology course. At present, 195 students are enrolled in various academic programs at the institute.

Community Outreach Activities

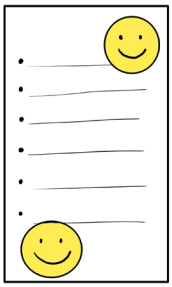
Serving as a Regional Cancer Centre, BBCI's impacts extends across the North East region. Based on 2023-25 data, under the project titled "Access to Affordable Cancer Treatment", BBCI has advanced its mission of making cancer care more accessible and affordable through extensive outreach programmes across Northeast India. More than 1,000 healthcare professionals—including CHOs, doctors, nurses, ASHAs, and community leaders—were trained in cancer prevention, screening, and tobacco control, with specialized hands-on training in gastric cancer screening. Screening programs reached over 5,000 individuals across Assam, Arunachal Pradesh, and Nagaland. In 2023-24, screening of common cancers (oral, breast and cervical) was performed at Pasighat, Arunachal Pradesh. In 2025, a pilot study on the project titled "Identification of Risk Factors for Risk Stratification of Screening Strategies to Prevent Gastric Cancer in Arunachal Pradesh" was initiated in Ziro, Arunachal Pradesh. Parallel awareness campaigns sensitized thousands of community members in schools, workplaces, religious institutions, and public spaces, with breast self-examination demonstrations and anti-tobacco advocacy. For research related interventions, a Knowledge, Attitudes and Practices (KAP) study is underway at Fatasil Ambari, Guwahati and an AI-based oral cancer screening project titled "A Point of Care Artificial Intelligence-Based Screening Tool for Oral Cancer" screened nearly about 7,000 people in community settings. At the systems level, BBCI contributed to policy development, health infrastructure gap analysis, and the establishment of Preventive Oncology Clinics and Chemotherapy Day Care Units in Assam and North East India. The Preventive Oncology Department of BBCI, established in 2003, conducts regular cancer awareness and screening camps across urban and rural areas of Assam and neighbouring states, focusing on oral, breast, and cervical cancer. Through its WHO–MoHFW supported Tobacco Cessation Centre (2005) and the National Tobacco Quit Line (2018), the department provides cessation counselling, quit-line services, and capacity building of health workers.

Future Plans

- Looking ahead, BBCI's focus is on building a stronger spectrum of care - from early detection and screening to advanced therapeutics and follow-up support.
- The establishment of Adult and Pediatric Hematolymphoid Unit at BBCI under PM-DevINE (Development Initiative for North East Region) Scheme of Ministry of DoNER (Ministry of Development of North Eastern

Region) and DAE is underway along with the development of an Ancillary Building in the campus of BBCI.

- In the coming years, new facilities in molecular pathology, cytogenetics, and therapeutic endoscopy will become operational.
- Efforts are underway to achieve self-reliance in bone marrow transplantation, exploring avenues for MUD (Marrow Unrelated Donors) transplants.
- Initiating CAR-T cell therapy.
- Exploring advanced modalities like robotic surgery, precision radiotherapy, and chemotherapy drug monitoring.



Good News Bulletin

Dr. Akshay Baheti
Professor, Radiodiagnosis

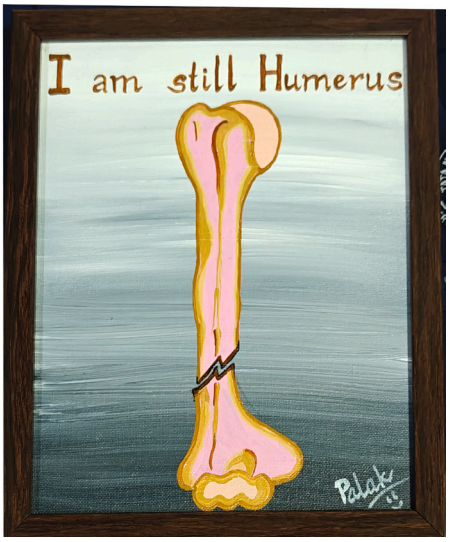
From PACS to Picasso

Radiology is seen as the black and white branch of medicine. X-rays used to be developed in a dark room in the days of yore. Most reporting rooms tend to be dimly lit to allow the eyes to appreciate more shades of grey on the image. He-Man had a castle of Grayskull; we have a castle of greyscale.

A stroll through the reporting room and corridors of the Dept of Radiodiagnosis though will provide a funky colourful palette which is in stark contrast to this dull hue. The walls are adorned by quirky pop art and hilarious memes, all created by radiologists!

The idea of creating radiology pop art germinated with a casual conversation on birthday parties with the then Cancer Imaging Fellow Dr Aashna. She described a memorable pop art-themed party her family had once organized on her birthday. The inspiration hit immediately. The Departmental Head Dr Suyash Kulkarni granted permission with a twinkle in his eyes, and a Friday was locked for the 'art extravaganza'. The leap of faith in our artistic abilities happened mainly thanks to a combination of lingering post Covid ennui and the comfort of having our very own in-house art guru Dr Vasundhara Smriti as partner-in-crime (and designated back-up artist for touching up cases taking 'excessive artistic privilege' - something which was eventually never required).

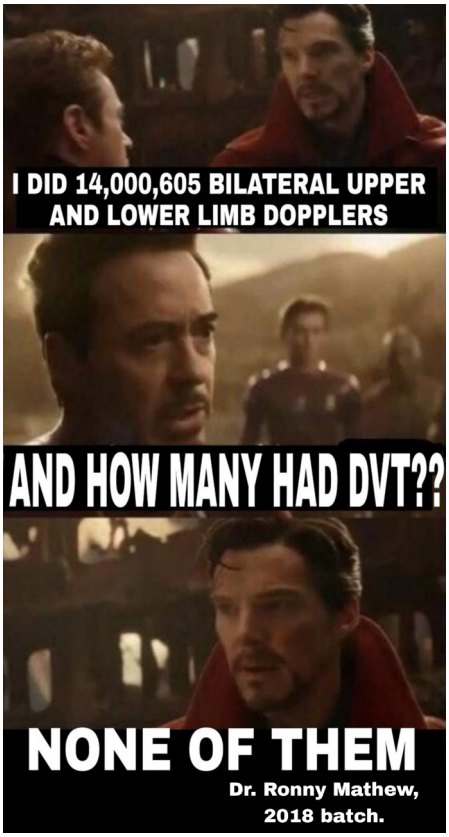
On the designated day, the reporting room transformed completely. Workstations, keyboards and mice were replaced by canvases, paints and brushes, and groovy music and pizzas created the perfect vibe. Many potential ideas had already been brewing on the departmental WhatsApp group, but what unfolded that evening exceeded everyone's expectations. Residents came in not only with enthusiasm but also with innovative concepts, executed with



considerable flair. From radiology signs and artistic renditions of radiological anatomy to tongue-in-cheek humor and 'good vibes only' pieces, a plethora of creativity erupted in those magical three hours. Latent talents were discovered and unleashed, with some of the work belying all expectations. The art created that evening now decks the once-monochrome walls of the reporting rooms, faculty corridors and imaging areas like radiography and ultrasound.

Having discovered the right-sided brains of so many residents and faculty and the impact of such light-hearted team building exercises, we knew this could not just be a one-off event. And so, Thank God It's Friday (TGIF) was born! Sessions such as karaoke, instrumentals, gym events, and finance management were conducted under the guidance of Drs Palak and Aparna.

The latest (and arguably the most entertaining) addition is the Radiology Meme Wall, courtesy our ex-resident the witty Dr Ronnie and his ilk, whose memes and mimicry have always left us in splits. While some are topical and will make those in the know break into a broad smile of amusement, many are universal, and I leave the reader with one of them as our take home message (wink wink)!



Hello's

Dr Aditya Dhanavat
Medical Oncology

Dr Aditya Dhanavat, Medical Oncology

A warm hello to all of you. It feels wonderful to be writing to you from the whirlwind that is Medical Oncology - where the chai is strong, the days are long, schedules run tight and somehow, our enthusiasm still runs high. Most of my time is spent between the OPDs and wards, juggling between cross-departmental phone calls and trying to stir in a tadka of precision oncology with seasoning of hope and compassion.

A bit about me: I am from Bhubaneswar (my janma-bhoomi) and studied at the Loyola School. Throughout my childhood, I was endlessly curious about science and how things work (and sometimes don't). Computer programming fascinated me and I had quite a grip in BASIC, C++ and JAVA back in school. I spent my free time playing basketball and strumming on the guitar. In 2008, when my father was diagnosed with CML, I shifted gears and was determined to become a doctor. I completed my MBBS from the prestigious SCB Medical College, Cuttack and MD in Internal Medicine from Kalinga Institute of Medical Sciences, Bhubaneswar. I was drawn to Medical Oncology because it offered an ideal blend of compassionate care and innovative research. I began my journey in Tata Memorial Centre on 1st October 2020 initially as a HBNI fellow in Solid Tumor and later went on to complete DM in Medical Oncology.

My parents have been my guiding light and instilled in me the values of humility and perseverance. My wife, Dr. Guncha, has been my rock - always nudging me to aim higher. Behind every night duty, every missed holiday, and every small victory, she has stood silently but firmly, holding our world together. We are blessed with a lively and spirited son, Arjun. Mumbai (my karma-bhoomi) inspires me. The city's unwavering professionalism is truly remarkable. As Robert Frost once wrote, "The woods are lovely, dark and deep. But I have promises to keep and miles to go before I sleep".

Dr Rukmini M Prabhu
Head and Neck Surgery

Dr Rukmini M Prabhu, Head and Neck Surgery

It is a pleasure to introduce myself as a new faculty member here at Tata Memorial Hospital in Mumbai. I was born in Delhi and was raised in the serene, coastal city of Mangalore, Karnataka. My mother, Dr Maya Prabhu, a gynecologist, has been my ultimate role model. After my father passed away when I was ten, she raised three children singlehandedly and showed me what it means to be a strong, independent woman. Her resilience has been the unwavering inspiration behind my journey into medicine. My family—my mom, my brother Govinda, and my sister Satyabhama (Gondi)—are my world. My educational path took me from Kasturba Medical College in

Mangalore for my MBBS to Bangalore Medical College for my MS. But the pinnacle of my training was right here, as I am proud to say I completed my MCh from Tata Memorial Hospital. It is a genuine honor to now be a part of this prestigious institution, a place that feels like home. I also have a great fondness for teaching, especially that invaluable moment when a concept clicks and you see someone have their 'Aha' moment. Beyond my professional life, I love the simple things: getting lost in a good book (especially a feel good romance or a juicy thriller) the satisfaction of solving a crossword or puzzle, and the meditative joy of coloring. And then, there's my love for food—from the science behind it to food history and the entertaining world of cooking shows. As Roald Dahl once said, "A little nonsense now and then is relished by the wisest men." With that spirit, I am truly excited to be a part of the TMH family.

Dr Latika Kansal
Head and Neck Surgery, HBCH Mullanpur

Dr Latika Kansal, Head and Neck Surgery, HBCH Mullanpur

My journey began in Jaitu, a small town in Punjab where my roots run deep. Growing up there, I developed a strong determination to serve my community. My true inspiration came during my time at Homi Bhabha Cancer Hospital, Sangrur, in 2017, where I first witnessed the immense need and life-changing impact of Head & Neck Oncology care in rural settings. It was there that I realized this was the field I wanted to dedicate myself to.

That spark led me to pursue formal training, including a fellowship at Tata Medical Center, Kolkata, and an MCh in Head & Neck Surgery from Tata Memorial Center, Mumbai.

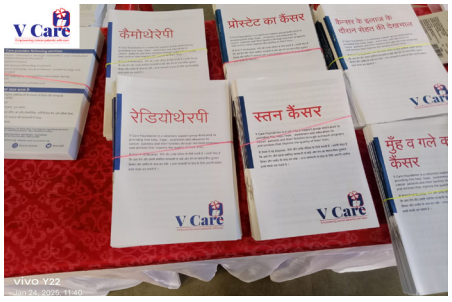
My time at Tata Memorial has been nothing short of transformative. I've had the privilege of learning from some of the finest mentors, working alongside incredibly dedicated colleagues, and growing each day both professionally and personally.

As my career continues to evolve, I have also developed a growing interest in activities beyond medicine, such as spiritual healing, education, and the practice of traditional dance. These pursuits enrich my life, providing balance and a deeper connection to my cultural roots.

Now, with gratitude and purpose, I return to where it all began to serve the very community that shaped me. I'm proud to contribute as an Assistant Professor at Homi Bhabha Cancer Hospital, New Chandigarh and Sangrur, advancing cancer care in Punjab and giving back to the land that gave me everything.

Thank you to everyone at Tata for being such an integral part of this chapter.

NGO Shoutout: V Care Foundation



V Care Foundation: Three Decades of Cancer Care from Chaos to Control

V Care Foundation emphasizes patient-centricity, ensuring that their patient caregiver programs bring "ease in their fight against cancer." Founded in 1994 by cancer survivor Vandana Gupta, V Care Foundation has evolved into one of India's leading pillars of holistic cancer support, making a measurable difference in the lives of lakhs of patients and their families. Over the last 31 years, the foundation's unwavering commitment has redefined the meaning of cancer care by seamlessly integrating emotional, financial, and practical assistance with medical support. The foundation's work is supported by trained patient navigators/advocates and partnerships with leading hospitals, allowing for extensive reach and tailored interventions. Emotional support and counseling are at the heart of their mission, empowering patients to make informed decisions and face their journey with resilience.

Care, hope, awareness, and education forms the bedrock of V Care's mission. Today, V Care's interventions range from counseling and tele-support to nutrition, pediatric, palliative, and financial aid, extending even during the COVID-19 pandemic to hospitals outside of Mumbai and also adopting technology to bridge support gaps. Collaborating with premier centers such as Tata Memorial Centre, V Care Foundation ensures that quality support reaches those most in need, regardless of background or region. Thanks to a robust patient navigator and volunteer network along with efficient governance, the foundation maximizes direct impact on patients and caregivers.

In the five-year period, V Care has positively impacted over 11 lakh patients, with continuity of support that not only eases burdens but significantly aids treatment adherence and patient morale. As a patient caregiver support group, its unique commitment lies in empowering patients at every stage—from diagnosis through remission and beyond. V Care's enduring legacy is one of hope, resilience, and lasting change for the cancer community and it truly

believes that a drop of kindness can create an ocean of change. V Care's work stands as a model of patient-centric cancer care, ensuring that those affected are supported beyond clinical treatment, with a network of compassion, guidance, and enduring commitment.

Facebook: www.facebook.com/vcarefoundationindia

Instagram - https://www.instagram.com/vcare.cancer/

Website: www.vcarecancer.org

YouTube -

https://www.youtube.com/channel/UC-9zYf1xJOqSnzwV3ZTTyKw

In a Flash

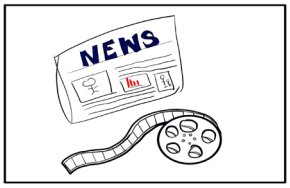
Inauguration of the 150-bedded HBCH&RH, Muzzafarpur by the Hon'ble Prime Minister Narendra Modi on Aug 22, 2025, a red-letter day for TMC!

Celebrating the next generation of healers and heroes: Convocation of the 2024 batch

Shaping minds, inspiring futures - honoring the Teachers!

Flag Hoisting on the Independence Day at TMH

TMH Tissue Bank was awarded the Best Tissue Bank on Indian Organ Donation Day by the Regional cum State Organ & Tissue Transplant Organization



Greater Kashmir/09/07/2025

India launches BIMSTEC cancer care training program under PM's 21-point action plan

Jointly organised by the Ministry of External Affairs and the Department of Atomic Energy, the four-week program will train 21 healthcare professionals from BIMSTEC member countries in Radiation Oncology, Nuclear Medicine, and Radiology

Punyanagari-Mumbai (Sub Edition)18/08/2025, P-3

प्रोटॉन थेरपीने दोन वर्षांत ५४१ रुग्णांना जीवद

टाटा मेमोरियल सेंटरची कामगिरी

■ मुंबई : येथे दोन वर्षांपूर्वी सुरू झालेले टाटा मेमोरियल सेंटरचे प्रोटॉन थेरपी सेंटर कर्करोग रुग्णांसाठी जीवनदाता ठरत आहे. अवघ्या दोन वर्षांत या अत्याधुनिक केंद्राने तब्बल ५४१ रुग्णांना नवजीवन दिले.

अँक्ट्रेकचे संचा पंकज चतुर्वेदी यांनी स की, 'ही केवळ एक उप नाही, तर कर्करो भारताची वैज्ञानिक आ लढाई आहे.' बीएड सहकार्याने प्रोटॉन आधारित अनेक संशोध सुरू आहेत. सप्टेंबरमध्ये बेलि

Sakal-Mumbai-26/03/2025, P-3

तंबाखूविरोधात 'टाटा'चा पुढाकार

मुंबई, ता. २५ : तंबाखू विक्री व नियंत्रणासाठी टाटा रुग्णालयाने पुढाकार घेतला आहे. राष्ट्रीय तंबाखू नियंत्रण कार्यक्रमातील प्रमुख भागधारकांसाठी दोन दिवसांचा प्रादेशिक सल्लामसलत यासाठी कार्यक्रम आयोजित करण्यात आला होता.

नवी मुंबई येथील या कार्यक्रमाचे उद्दिष्ट महाराष्ट्र, कर्नाटक, गुजरात, झारखंड आणि तेलंगणा येथे राष्ट्रीय तंबाखू नियंत्रण कार्यक्रमाची अंमलबजावणी मजबूत करणे हा होता. या वेळी टाटा मेमोरियल सेंटरच्या अँक्ट्रेकचे संचालक डॉ. पंकज चतुर्वेदी यांनी सांगितले, की देशात तंबाखू सेवनाने दररोज ३,५०० मृत्यू होत असल्याने तंबाखू नियंत्रण हे

an

Business Line -Mumbai -07/08/2025, P-15

National Cancer Grid's bargaining power helps it push pharma firms for 85% discount on drugs

PT Jyothi Datta
Mumbai

Group negotiations and pool procurement have delivered an average 85 per cent price discount on cancer drugs for cancer centres that are part of the National Cancer Grid (NCG). The next step is to take a similar approach — negotiate and procure as a group — for surgical items and possibly medical equipment, Dr CS Pramesh, Director, Tata Memorial Hospital and NCG Convener told *businessline*.

Funded by the Centre's Department of Atomic Energy, the NCG is a collaborative network of over 38 cer centres, re institutes, patient and professional socie India and 15 other cou Together, they treat

NCG hopes to extend the bulk negotiation model for procuring surgical items and possibly medical equipment, said CS Pramesh, NCG Convener

8.60 lakh new patients annually, or 60 per cent of all cancer patients in India.

COMPETITION DRIVEN

The NCG's group negotiation and pool procurement

The most expensive drugs in key hospitals were mapped and price negotiations brought in discounts between 23 per cent and 99 per cent, he said. The lower discount was for innovator drugs that had no competition or had generic variants available. On average, the NCG has been able to get over 85 per cent discount on the maximum retail price consistently since 2019.

The drugs are procured through a tender process, and the quality is assessed through a scoring system before the financial bids are opened, he said. "This ensures quality drugs are got at

across centres to provide high quality drugs at low cost, he said.

OTHER CONCERNS

The pooled procurement success was among the key features discussed at a recent NCG meet in Mumbai.

Other features discussed included revised treatment protocols used for reimbursement by the National Health Authority; implementing the Ayushman Bharat health insurance scheme; quality assurance programmes; capacity building for para-medical staff and all professionals involved in cancer treatment;

Navbharat Times-Mumbai-28/07/2025, P-3

मुंह-गले के कैंसर की रोकथाम के लिए डॉक्टरों को प्रशिक्षण

Navbharat Times-Mumbai-28/06/2025, P-1

न्यूरोब्लास्टोमा कैंसर के लिए उम्मीद बना टाटा

देश में पहली बार दी गई हाई डोज रेडियोथैरपी

Suraj.Pandey@timesofindia.co

■ मुंबई: टाटा मेमोरियल ने पहली न्यूरोब्लास्टोमा से पीड़ित 17 वर्षीय की 1311-mIBG नाम की रेडियो की 800 माइक्रोक्यूरी खुराक देकर इ किया है। यह सफलता उल्लेखनीय जो मरीज महंगा विदेशी इलाज नहीं सकते, उन्हें फायदा मिल सकेगा।

न्यूरोब्लास्टोमा बच्चों में होने वाला है। इसमें नर्वस सिस्टम प्रभावित होत पीडियाट्रिक ऑन्कोलॉजी विभाग के प्र डॉ. गिरीश चिन्नास्वामी ने बताया कि में 1500 और मुंबई में 100 मरीज हर आते हैं। 30 से 40% ठीक हो पाते मरीज को कीमोथैरपी, सर्जरी, स्टेम ट्रांसप्लांट, रेडियोथैरपी और इम्यूनो की जरूरत होती है। इस कैंसर के एंटी-GD2 इम्यूनोथैरपी उपलब्ध लेकिन कीमत 75 लाख रुपये है। भार

Punyanagari- Mumbai-27/07/2025, P-3

कर्करोग प्रतिबंधासाठी 'अॅक्ट्रेक'मध्ये राज्यस्तरीय प्रशिक्षण

■ मुंबई : जागतिक डोके आणि मान कर्करोग दिना (२७ जुलै) निमित्त कर्करोग प्रतिबंध आणि लवकर निदानाचे महत्त्व अधोरेखित करत टाटा मेमोरियल सेंटरच्या अॅक्ट्रेक आणि कर्करोग महामारी विज्ञान केंद्रातर्फे महाराष्ट्र शासनाच्या सार्वजनिक आरोग्य विभागाच्या सहकार्याने २३ जुलै रोजी एकदिवसीय प्रशिक्षणाचे आयोजन करण्यात आले.

या प्रशिक्षणात महाराष्ट्रातील विविध जिल्ह्यांतील वैद्यकीय अधिकारी, तसेच मुंबई व नवी

मुंबईतील दंत आणि वैद्यकीय महाविद्यालयांचे प्रतिनिधी सहभागी झाले होते. तोंड आणि डोक्याच्या कर्करोगाच्या प्रतिबंध, तपासणी आणि लवकर निदानामध्ये वैद्यकीय अधिकाऱ्यांची भूमिका अधिक प्रभावी करण्याचे कार्यक्रमाचे मुख्य लक्ष्य होते.

'क्लिनिकल प्रॅक्टिस आणि सार्वजनिक आरोग्य व्यवस्थेतील दरी भरून काढण्यासाठी वैद्यकीय अधिकाऱ्यांनी पुढाकार घेणे आवश्यक आहे,' असे मत टाटा मेमोरियल सेंटरच्या अॅक्ट्रेकचे संचालक डॉ. पंकज चतुर्वेदी यांनी व्यक्त केले. त्यांनी लवकर निदान आणि समुदायाधारित कर्करोग नियंत्रणाचे महत्त्वही अधोरेखित केले. कर्करोग महामारी विज्ञान केंद्राचे संचालक डॉ. राजेश दीक्षित यांनी जागतिक पातळीवर कर्करोगाचा वाढता भार आणि जोखीम घटकांवर प्रकाश टाकला. 'कर्करोग नियंत्रणासाठी प्रतिबंधक उपायांवर प्रभावी सहकार्य आवश्यक आहे,' असेही ते म्हणाले.

Home > Bihar

PM Modi Inaugurates Bihar's First Homi Bhabha Cancer Hospital, Aims to Boost Regional Healthcare

August 22, 2025

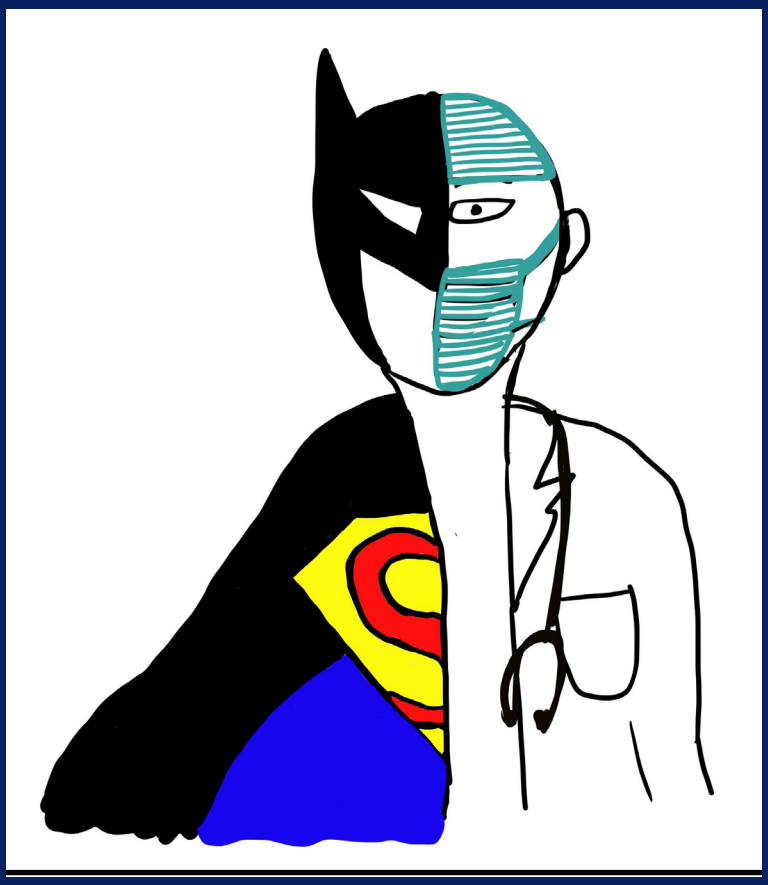
दैनिक भास्कर

23 को टाटा मेमोरियल कैंसर हॉस्पिटल का उद्घाटन होगा

दरभंगा सदर 8 महीने पहले

भास्कर न्यूज | दरभंगा सदर स ऐप खोलें गंगा के प्रभारी मंत्री मंगल पांडेय 23 जनवरी को सदर प्रखंड के गंगवारा में 50 करोड़ की राशि से गौशाला की

The Doctors' Lounge



A tribute to my mentor

Dr Pankaj Chaturvedi
Director, ACTREC
pictured here with

Dr Rajendra Badwe,
ex-Director TMC

It was a hot and humid September afternoon in 1996. It was my 3rd month in Tata Memorial Hospital, Mumbai as a junior resident and it was the first day in the thoracic surgery unit. I had never seen thoracic cancer patients in the past. I was completely lost and nervous. I was sitting in the OPD all alone while all the seniors were busy in an emergency surgery in the operation theatre. It was already 6 pm and nearly 30 patients were waiting for finalization of their treatment plan. Except for checking their investigations and doing clinical examination, I had zero knowledge of the further management. A couple of patients were getting agitated. The OPD ward boy told me that since none of the senior residents are available, I can call up the Junior Consultant of the unit whom I had never met. It was against the code of conduct at TMH for the JR to directly speak to the consultant that too on the first day itself. I rejected the idea outrightly. However, the ward boy was very courageous and he called up the Junior Consultant (JC). In 10 minutes, a tall and handsome person walks in the OPD in scrubs with the apron hanging on the right shoulder. I was shivering with fear anticipating a reprimand for my misconduct.

The JC, on the contrary, asked my name and enquired why I was all alone. He sat next to me and I explained him about each patient. What impressed me is that he took less than 2 minutes to decide on the treatment plan for most of the patients once I presented the case history. He asked me to keep 3 particular patients to be discussed once we are done with the remaining. One of those was a young patient having recurrence of esophageal cancer and he was brought on a stretcher because of very poor general condition. There was another patient of incurable lung cancer with pleural effusion who was very breathless. The third one was a locally advanced stomach cancer planned for surgery 2 days later. The JC asked me to call the relatives of these 3 patients after we finished other patients. At this point the ward boy rushed inside the OPD and informed the junior consultant that his son at home was having difficulty in breathing. To my surprise, rather than leaving the OPD immediately, Junior consultant continued the consultation patiently. I suggested that I will discuss these cases with the SR and he could go home. He said these sick patients also needed his attention and it was equally important. Laughingly he said, perhaps the good wishes of these patients

may enhance the recovery of his son. He looked at the scans of the 70 years old stomach cancer patient and then told me that it was not worth the surgery. I told him that the senior consultant had already opined for surgery and the OT was already scheduled. He gently tapped my shoulder and said "we are surgeons and we should not think we are God". He told to think as if the patient was my father and if I would plan the same for him. He called the relatives of the lung cancer patient with pleural effusion and explained the futility of any further treatment. The patient was advised palliative chemotherapy by the medical oncology team. He convinced them that the chemotherapy will prolong the suffering and not the life. For the young man with the recurrent esophageal cancer, he tried to convince the relatives to take him home. However, the relatives insisted for admission and they were not able to accept that the disease was not curable. We finally conceded and planned to admit him though I could have sent him away by explaining non availability of the bed. Next morning, when I and the JC were taking morning ward rounds, we got a distress call from the 10th floor Radiotherapy ward where the recurrent esophageal cancer patient was admitted. The patient committed suicide by jumping from the window of the toilet. Several weeks later, the relatives of the patient came to the hospital and donated 1 lac in the memory of the patient. The JC often said, a good doctor is the one who continues to be respected even when the patient has died. We should give extra care and attention to the patient once they reach end of their life.

The next day morning I was assisting the senior consultant of the Breast and Thoracic unit in the operating room. JC walked in the OT somewhere in the afternoon. The senior consultant curtly told him that he was not wanted in the OT and he should go and finish the ward rounds. The whole incident was quite upsetting even for a JR like me. In the afternoon, I was told that the OT list was decided by the senior consultant and JC's private cases should not be accommodated! In my 3 months of rotation, I witnessed several instances of him being sidelined or ignored. JC never expressed his displeasure publicly at least in front of the residents of the unit. On the contrary, we were greeted by a smiling face whenever we reached him. He ensured that residents never suffered due to his relationship with his senior. While leaving the unit, I gathered the courage to ask him about the secret of his "inner peace." He calmly told me two things. Firstly, such bosses teach you what not to do when you become the boss. Secondly, no one can take away your talent from you….stoop to conquer.

Three months later, a dedicated Breast Oncology unit was formed with JC being one of the consultants in it. I was fortunate to be the first SR of the first dedicated breast unit. I was exposed to a whole new vocabulary such as evidence-based medicine, equipoise, randomized control trial, paradigm shift, logistic regression, clinical research methodology, diseases management group etc. I witnessed the origin of an idea that was going to transform TMH forever and give platform for JC's meteoric rise. These memories of working with this extraordinary JC named Dr Rajendra Badwe are still etched in my memory even 27 years later. I had the fortune of having a mentor like him.

After completing my residency at TMH, I moved to a trust

run cancer hospital in Bhopal in 1999. Three years later, faculty posts were advertised in TMH and I too applied for it. I was a bit hesitant in appearing for the interview because there were several candidates who were either children of senior TMH doctors or close to them. Moreover, being a typical Bhaiya (a North Indian) by action and thoughts, I never thought I had the caliber and smartness that was needed for a TMH faculty. I met Dr Badwe for his guidance and to get some tips from him. I asked him if he wanted me to read any specific book for preparation for the interview. To my surprise he handed me a book titled "The Art of Healing." He said, he is looking for a compassionate surgeon and not an accomplished surgeon to build his team. On the evening of the interview, I got a call from Dr Badwe that I was selected as a faculty and I should prepare to join earliest. I was choked with emotions. It was a dream come true. I appreciated the humility of Dr Badwe who found time to make a phone call and inform the results to a fresher.

Four years after joining TMH, I decided to engage myself in advocacy for tobacco control. This involved working with the media, politicians, bureaucrats, lawyers, NGOs etc. My critical views against government policies started appearing in newspapers frequently. I started meeting political leaders and IAS officers to push for effective tobacco control, especially banning Gutka. Many of them did not like a government doctor indulging in such lobbying. Once an IAS officer visited TMH and expressed his strong displeasure against my activities. At the height of my advocacy, I started getting threats from the tobacco industry. TMH started getting several RTIs seeking detailed information about my funding, activities, meetings, travels, spending etc. Several anonymous letters were sent to the hospital terming me as cigarette industry secret agent unleashed against gutka industry. Those were very difficult days of my life. Dr Badwe stood like a rock behind me and shielded me from the evil forces. He told me if you are honest in your work, you have my full support. It was simply because of his unconditional support and encouragement that I could succeed in tobacco control in India.

In December 2017, he called me and told me on phone that we must rush to Varanasi the next day. What happened subsequently changed the course of my life forever. He entrusted me with the responsibility of building a 500 bedded hospital in Varanasi with support of Tata Trusts in 12 months! This involved renovation of an existing railway cancer hospital and construction of a new hospital inside BHU campus. At that point of time, I had no knowledge or experience of doing such as job. What motivated me was his implicit faith in me and the total freedom he gave me for the next one year. It was a 1100 crore project that was monitored by the Prime Minister office for its completion by February 2019. The challenge was that we started the construction in April 2018! I was thrown into the rough waters and I had to learn to swim. What kept me going was Dr Badwe's trust in me. Once he told me that no doubt that leaders are born but someone must identify them! In his stint as the Director TMC, he opened new hospitals in Sangrur, Mullanpur, Varanasi, Vishakhapatnam. He also got the approval for construction of the hospitals in Muzaffarpur, Odisha and Raigad. He also continuously worked for the augmentation of TMH as well as ACTREC. Given the system where we work, I can now imagine how stressful this entire journey must have been. His mantra of "delegation" and identifying one senior medical faculty to lead each big project did the magic. He gave opportunity to many senior faculty to demonstrate their leadership skill by giving them big tasks. This led to the emergence of several leaders within TMC who could manage tough administrative tasks and challenging responsibilities independently.

There are other good qualities that I learnt from him. I had the fortune of accompanying him in flights several time when he could not use his phone. One thing that always struck me that he never criticized or bitch about anyone. He has kind words for to his adversaries too. He is always approachable on phone to an extent that anyone can call him and get a response. His secretary offered 3 options when we went for meeting him in the office – Free, Busy or On Phone. Despite his busy schedule, he gives a patient hearing to anyone who meets him. His kindness and "giving"

nature created a challenge for the administration. Anyone who was retiring (from housekeeping staff to heads of departments) will make a visit to Dr Badwe and return with an approval for their extension. His communication and care for the patient is exemplary. The Kevat program that he introduced is an example of his patient-centric approach. He has also broken the age old myth that handwriting is the reflection of an individual's personality. He probably has one of the worst handwriting ever seen in human history.

Despite all the hurdles and complexities, he always maintains a calm and composed demeanor. He exudes positivity and affection. His biggest problem is that he cannot say "no" to anyone (including the offer of sweets). There was a time during my stint in his unit when he sanctioned leave for all 3 senior residents during Diwali Festival that too when he had also planned a holiday. We receive multiple requests from politicians or philanthropists for building cancer hospitals. He would assure every one of assistance and promptly forward the request to me. Once I asked him, why can't he be a little pessimist and discourage them? He said, just send them a customized report regarding money, machine and manpower needed for a cancer hospital; that itself is enough to discourage them. The last 5 years, I literally worked with him as his executive assistant. I have been working with him on the projects in Varanasi, Muzaffarpur, Odisha, Khopoli apart from several other important assignments. I would draft the letters/responses for him and he would take less than a minute to approve or at times will not even read it. I realized that, this implicit trust forced me to prepare flawless drafts despite my Hindi medium background.

Dr Badwe's glorious stint as the Director of Tata Memorial Centre will come at an end on 30th November, 2023. The institution has grown from a 600 bedded hospital to 3000 beds in 6 different states with 6000 employees. From a service (treatment) center, it has diversified into an educational and research giant. The institution will not be the same without him. I am confident that the new leadership will fill the void and continue his mission. I was fortunate that I could learn these unique skills from Dr Badwe while working with him. This invaluable experience has made an everlasting impact on my professional and personal life. We feel blessed that he will continue to inspire us by working as a Professor in the Breast unit.

The true measure of a successful career is not how many awards you have won but how many hearts you have won. True respect is not the one you get when in power but the one you receive when out of power. Finally, whatever you do comes back to you.

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The Teachers I'll Always Remember

Shabnam Bano
Senior Resident, Radiation Oncology

When I was asked to write about Teachers' Day, I began thinking about the one teacher who had the greatest impact on me. But then I realized—limiting this to a single person would be unfair. Life introduces us to many people, both young and old, who teach us in different ways, who inspire us to be better versions of ourselves. Each one leaves a mark, sometimes knowingly, sometimes unknowingly.

My mother was my first and most consistent teacher. She taught me the art of giving—of understanding others' needs even before they voice them. I was a shy child, hesitant to ask for anything. But she always anticipated my needs—sitting beside me during meals to fill my plate before I asked, packing snacks for school, giving me money before I even knew I needed it. To the world, it may look like pampering, but to me, she taught compassion, attentiveness, and the value of silent care.

I remember an incident from school. I was using a chalk, and a teacher asked me, "Shabnam, is this your property?" I replied confidently, "It belongs to the school—and this is my school, so it's my property." She gently corrected me and explained that public property, though available to us, is not for personal use. That was a lifetime lesson. Even today, when I think of using even a hospital stapler for my own purpose, it feels wrong. That small conversation shaped my sense of ethics.

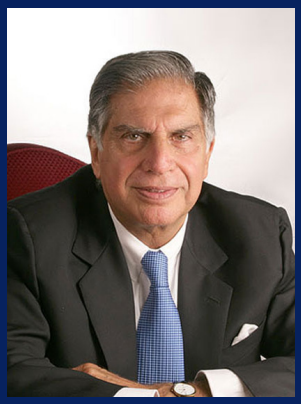
Another memory goes back to a day we were being punished for not doing our homework. I was deeply upset, especially because back then, physical punishment with a stick was common. But before the punishment, our teacher told us a story. It was about three servants who disobeyed a king. One was sent home without a word, one was fined with coins, and the third was humiliated publicly—made to sit on a donkey, wear a garland of shoes, and paraded through the streets. When people questioned the inconsistency in punishments for the same mistake, the king asked them to check on the three. They found the first servant crying in despair, the second feeling ashamed but quiet, and the third laughing and enjoying the donkey ride. The king said, "You can't treat everyone the same way. People respond differently." After that, our teacher began to punish us—some got ten sticks, some five, some just two. I wasn't punished at all. That day, I learned that true fairness is not in treating everyone the same, but in understanding how each person learns and grows differently.

In my Urdu-medium school, a semi-English batch was introduced when I was in 8th standard. Afraid I wouldn't manage, I chose to sit in the regular Urdu batch. Our headmistress walked in, noticed me, and firmly told me to sit with the new batch. She assured me that if there was any problem, my mother could talk to her. But when I asked my mother to speak, she felt intimidated and simply said, "Do as she said." And so, I did. It turned out to be a good decision in the long run. That teacher taught me that sometimes, as mentors, we must push our students beyond their comfort zone—and that using one's authority for someone else's growth is an act of care.

After 10th grade, my father was unsure about continuing my education—girls' education was still uncommon in our community. One day, we visited our family ophthalmologist. He casually asked me about my studies. Seeing my interest and my father's hesitation, he spoke to him for half an hour, encouraging him to let me study further. It wasn't his responsibility, but he took the time. That day I learned: if you're in a position of influence—where people respect and listen to you—you have a moral responsibility to intervene when it matters. A small act of concern can change someone's life.

Years later, I saw one of my colleagues in the physics department—smart, hardworking, always cheerful. For three years, I believed she was living a perfect life. Then one day, she confided in me, revealing deep personal struggles. I was shocked. She taught me one of the most profound lessons: struggling silently does not mean you stop living with dignity. Just because life is hard doesn't mean you get bitter, sulk in a corner, or lash out. She taught me how to carry pain with grace, and how to push back just as hard when life pushes you.

Each of these people—teachers, family, friends—taught me something invaluable. Some through their words, others through actions. This Teachers' Day, I don't celebrate just the formal teachers, but all those who shaped my thinking, my values, and my heart.



Quote of the Quarter:

If you want to walk fast, walk alone.
But if you want to walk far, walk together.
- Ratan Tata

Quote submitted by
Dr Dushyant Jaiswal, Plastic and Reconstructive Surgery

The Silent Teacher: Lessons Beyond the Disease

Dr Sunidhi M. Ghatikar
JR1, Radiation Oncology

"Science treats the disease, but it is humanity that truly heals the patient."

This is a lesson that Tata Memorial Hospital (TMH) engraves into the very soul of oncological care.

Walking through the vast corridors of TMC, one encounters many sights - from humble fruit and chai vendors, to anxious families moving in hurried steps, to experts immersed in their work. Yet, not all of these impressions reach the emotional core of our minds, the limbic system. What does leave a mark are the quiet lessons in compassion and resilience that unfold every day.

When navigating the unknown, kindness - whether given or received - goes a long way.

Amidst the ever-brewing coffee and endless rush, some days feel heavier than others. Not because of fatigue alone, but because you find yourself leaning into your humanity more than your clinical detachment. It is in those moments that you witness:

A daughter who once rode proudly on her father's shoulders, now lending her own strength to carry him and the family through illness.

An elderly man pushing his wife's wheelchair, cracking jokes to make her laugh as he carefully manoeuvres the turns and floors.

A toddler, unable to run on his own, giggling as his uncle races him down the corridors in a wheelchair.

Life is rarely easy. But it is perhaps hardest when lived under the shadow of mortality, knowing that illness may separate us from those we love. Yet amidst these struggles, TMH stands as a living legend - shaping stories of courage, sorrow, hope, and healing for all, privileged or otherwise.

Here's to the silent teacher - the hospital itself - that fosters an ecosystem of knowledge, compassion, and patient care so profoundly.

Thank you, TMH.

Dr Pramatha Mulay,
Dept of Plastic and Reconstructive Surgery

A Slice of a Surgeon's Life

The day begins, bright and fresh,
And I don scrubs of blue,
Always ready and excited,
To learn something new!

Entering the operation theatre,
Preparations are in full swing
I look at the shiny instruments and radiant lights,
For me, THIS is glamour and bling!

The patient is being put to sleep,
Last minute checks are in fifth gear,
It's time to wash up and wear my gown,
At last, show- time is near!

As I walk upto the operating table,
A deep breath I take,
Rehearsing all the steps in my mind,
Even a single error I must not make.

The nurse hands me the knife,
And as I place it on the patient's skin
I think of the trust placed in me
Hers, and that of her kin.

I proceed with the task at hand,
Meticulous cuts and dissection
For this requires a lot of skill
And must be done to perfection!

The feeling is indescribable,
Of the right plane, a flawless stitch and a perfect knot
And it goes without saying,
That this requires practice - a lot!

The surgery has gone well,
Which is every surgeon's prayer
And I thank the Almighty,
As I close the incision - layer by layer.

The operative sites are dressed,
And as I scrub out
I thank the anaesthetists, nurses and OT help
Nothing would be possible without.

The patient slowly wakes up,
And looks at me with seeking eyes,
I tell her all has gone smoothly
Her relief she cannot disguise!

Little does she know,
That I too was anxious,
Knowing what all could have gone wrong
Made me even more cautious!

As the patient is wheeled out,
I too leave the operation theatre
Pondering about my performance,
And what I could have done better.

I reach home in the evening
A hot cup of coffee I pour,
That was a day in a surgeon's life,
It is definitely worth waking up for!

Dr Gunjan Singhal
Junior resident
Radiation oncology

Tell me without telling me

They are warriors
They do not carry guns or shields, just will
They don't give up
They come in everyday, in all sizes, all shapes
Sometimes walking, sometimes staggering
They don't give up
Many know the routes by heart
Maneuvering, day after day
The twists and turns, the waitings, the calls
Bone-tired, still if a stranger asks for help
they stay
They don't give up
They fight, for themselves, for their kin
Sometimes with themselves
They will sit
They will cry
They get up
They don't give up
It makes me wonder how outsiders call this place depressing
This is where the strongest walk among us, quietly,
teaching what courage means

-To those who teach us strength everyday

Dr Rishika Mody
SR1,
Radiation oncology

She sat there as still as the Sea,

When Sand - her love, now rested in eternal sleep- chose to separate and become thebeach.
Her only thought was to guard what family remained to be,
To nurture her little one, as nature sought to teach.

When the wicked Crab decided to cook up a storm,
The beautiful strong Wave that she created with the Sand was in his mid twenties,
The Crab completely demolished the wave's form,
And drained all of the Sea's pennies.

Asclepius extended hope by offering to help;
He brought with him Pacific yew and Periwinkle kelp.
He regulated the dosage to be cyclical like the Wave,
And suggested, despite the adversity - a Patient must continue to be brave.

The Mother watched her only child endure the pain,
As the Sea trembles when her wave breaks too soon on the shore.

She feared their struggle might all be in vain,
For if the Wave did not heal, he too would be lost to the stillness of the beach.

-Dr Shreya Dhingra
SR1, Radiation Oncology

On Being a Student in the Era of AI

Being a student of medicine has always meant living with questions, some asked by our teachers, some by our patients, and many by ourselves. Every Teachers' Day, I pause to think about those who have shaped me: professors who taught me physiology on the blackboard, senior residents who guided my first radiotherapy contours, consultants who balanced evidence with empathy, and above all, patients who have been my most enduring teachers.

Now, as an oncology trainee in 2025, I find myself learning in the era of artificial intelligence. On one hand, I inherit the timeless rituals of medicine: late-night reading, heated debates in tumor boards, quiet moments at the bedside. On the other, I am surrounded by a force that is rapidly reshaping how we learn and practise: AI.

At times, AI feels like a teacher of its own kind, always available, infinitely patient, astonishingly fast. It can summarize fifty papers in seconds, suggest optimal dose plans for complex cases, or tell us whether a chest radiograph is normal or abnormal. In research, it accelerates literature reviews and analysis that once consumed weeks. As a student, this abundance of knowledge feels like a privilege unimaginable to generations before us.

And yet, I often ask myself: Can AI truly be my teacher?

Because the essence of teaching, as I have known it, lies not in answers but in shaping the way we think, question, and care. My mentors in oncology did not teach me only about DFS curves or radiotherapy dose prescriptions; they taught me how to sit with a family in silence after breaking bad news, how to balance the elegance of data with the messiness of humanity, how to accept that medicine is as much about uncertainty as it is about precision. These are the lessons that no algorithm can impart.

In fact, in this AI era, my human teachers are more important than ever. They remind me that while AI can be a guide, it must never be the guru. It can sharpen reasoning, but it cannot teach judgment. It can predict outcomes, but it cannot teach courage. It can process information, but it cannot inspire.

In oncology, I see this duality daily. In tumor boards, AI quietly annotates

scans and predicts risk. But in clinic, when I must decide whether to escalate or de-escalate treatment, when I must look into a parent's eyes and explain the limits of science, it is not an algorithm I turn to, it is the wisdom of my teachers. Their words echo in my mind, anchoring me to what truly matters.

So perhaps the right way to see AI is not as a teacher, but as a teaching assistant. It helps, it simplifies, it accelerates. But the irreplaceable role of true teachers is to show us how to wield such tools without losing ourselves, to preserve rigor, humility, and compassion in the face of technology's temptations.

To be a student in the AI era, is to walk a tightrope. On one side lies the immense opportunity to learn, innovate, and accelerate; on the other lies the risk of laziness, over-reliance, and detachment. Our task is to balance, to let AI sharpen but never replace curiosity, to let it enhance but never erode empathy.

This Teachers' Day, I realize that the greatest lesson my teachers continue to give me is not how to outpace AI, but how to remain deeply human alongside it. Because no matter how powerful the algorithms become, the heart of medicine, and the heart of learning, will always be human.

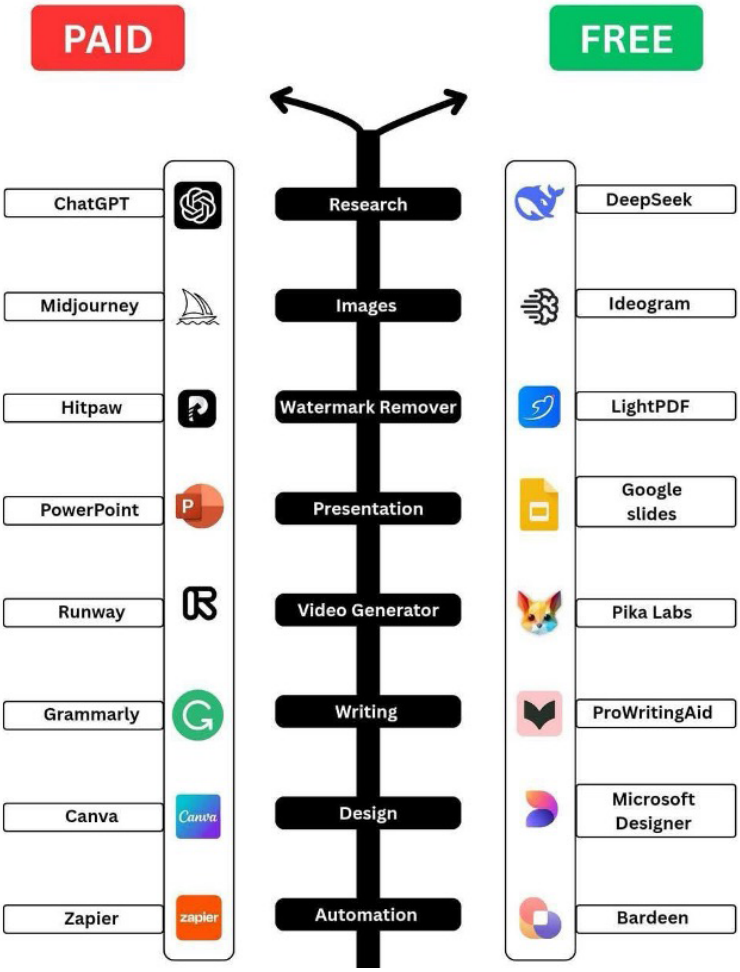
As we celebrate Teachers' Day and reflect on the balance between human wisdom and technological progress, it feels fitting to also share some practical ways in which AI can act as a helpful companion in our daily work and learning. Here are a few AI tools that might be of help in reading, research, and practise.

Paid Tools

- Chat GPT: Like that senior resident who always has an answer, day or night.
- Mid Journey: For when you want to draw anatomy better than Netter themselves.
- Hit Paw: Because even your tumor board videos deserve a clean shave.
- PowerPoint: Still the stethoscope of presentations - essential, reliable, and everywhere.
- Runway: As precise with videos as IMRT is with dose delivery.
- Grammarly: Catches mistakes the way PET/CTs catch hotspots.
- Canva: Designs posters faster than you can contour a prostate.
- Zapier: Your invisible intern, automating all the boring clerical work.

Free Tools

- Deep Seek: Your AI radiologist for literature, always hunting for subtle findings.
- Ideogram: Turns text into images faster than pathology stains a slide.
- Light PDF: Because consent forms and CRF's shouldn't be a painful task.
- Google Slides: The humble white coat of presentations: simple, trusted, indispensable.
- Pika Labs: Breathes life into static images, like chemo shrinking a bulky mass.
- ProWriting Aid: Your language oncologist, spotting errors before they metastasize.
- Microsoft Designer: Dresses up your figures the dose painted IMRT way.
- Bardeen: Automates the routine like a protocol-driven chemo regimen.



Humor in Science

Dr Hemant Morparia is a full-time radiologist at Breach Candy Hospital, alongside a professional cartoonist with over 17,000 published cartoons to his credit, having published in most major Indian newspapers, as also international ones including New York Times, Toronto Star, and Charlie Hebdo. His big takeaway from being in these two diverse fields is that issues and tissues are never black or white but always in shades of grey.

(Cartoon printed with permission)

A Journey of Growth: A Teacher's Day Tribute

Abhishek Diggaonkar
SR, Radiodiagnosis

Why? How? These simple questions always arise when we step into something new. And nowhere do they feel more intense than in the medical field, where everything is unfamiliar and often overwhelming. After the initial steps of MBBS, when we enter the postgraduate phase, those questions don't just remain — they multiply. With them comes a wave of new anxieties, each one more daunting than the last.

Despite the uncertainty, there's something else quietly present: a spark of curiosity, a flicker of love for the branch we've chosen. It's a mix of excitement and fear, but also hope — the hope that one day, we'll understand it all.

In this journey of life, we begin with zero knowledge. The very first word we speak — "maa" — is taught to us by our mother. From then on, everything we know is something someone has shared with us. Sometimes, it's through their patient guidance, holding our hands and showing us the way. Other times, it's through observation — we learn by copying their actions. We may even learn through discipline and correction, or simply by being present in the moments they lead. As humans, we are naturally inclined to learn from those around us — our parents, our peers, our friends, and, most profoundly, our teachers.

Today, on Teacher's Day, I want to take a moment to honor all of you — the guides, the mentors, the ones who have shown us the way. A heartfelt thank you for helping us see the wisdom hidden in the seemingly black-and-white world of radiology. Without your teachings, we would not be able to offer the care and precision that our patients deserve.

I wish we could keep walking beside you, learning from your vast knowledge of the radiology world, until the day comes when we've grown enough to pass on the same lessons to those who follow. Your wisdom has shaped us, and we can only hope to do the same for the next generation.

Letters that Shape(d) Us

Dr Mahak Gupta

A is for answers patiently given, and aspirations sparked in silence, for axial slices, arc therapy, and the accuracy that defines our daily discipline.

B is for the books we treasure and the beacons who guide us, and for bolus, beams, and the balance between radical and reasonable.

C is for compassion, both taught and shown, and courage quietly contagious; it is also for contours- painstaking, precise, and often poetic.

D is for dedication-day after day, and doubt that's met with direction, as well as for dose constraints, and the discipline to respect them.

E is for empathy, the essence of every lesson learnt, and for electron portals, EBRT, and energy delivered with understanding.

F is for failures and feedback that shapes futures, for fractionation- a rhythm that echoes through our lives.

G is for growth - in knowledge, kindness, and grace, and for gamma cameras, GTVs, and the guidance we hold close, even years later.

H is for hope, held gently like a candle in the dark, and for hyper/ hypofractionation, and the humility to admit what we don't know.

I is for inspiration, found in every hallway, ward, and classroom, and for IGRT, and intent- curative or palliative, but always patient-centred.

J is for journeys -not just of patients, but of people becoming teachers, and for jaw settings, and justifications- clinical, ethical, human.

K is for knowledge, shared like water without holding back, and for Karnofsky scores, and the kindness to treat the person, not just the prognosis.

L is for listening deeply, even when nothing is said, and for linacs, leads, and the legacy our teachers leave behind.

M is for the mentors who model not perfection, but perseverance, and for monitor units, MU calculations, and the mentorship that calibrates us.

N is for nudges- subtle, firm, and full of belief in you, and for normal tissue tolerances, and the nuance of decision-making.

O is for observing, the first lesson in every discipline, and for oncologists, and the silent oaths we take during night shifts.

P is for patience, with protocols and people alike, and for planning scans, port films, and the patients- the purpose behind it all.

Q is for qualms-the kind that drive us to plan better, questions that make us think deeper, and for quality assurance, the conscience of every treatment plan.

R is for rounding- teaching, even when unplanned, and for RBE, radiobiology, and respect for the past and future of our field.

S is for stories- of survival, of science, of silent strength, and for simulation, where it all begins- with silence, lasers, and for the seniors who guide us.

T is for teachers, not always titled so, but remembered always, and for treatment time, Treatment Planning System, and the trust we earn, fraction by fraction.

U is for understanding, which heals more than medicine, and for uncertainties- in margins, models, and human behaviour.

V is for values, held high even in exhaustion, and for VMAT, verification, and values that outlast vitrified plans.

W is for wonder- at the human body, and the human bond- and for wedges, washouts, and the wisdom to know when less is more.

X is for the X-rays we study, our daily dose of discipline, and for the X-factor of empathy.

Y is for the yes we say to the next generation, every time we teach, and for yields- of audits, of effort, of empathy.

Z is for the zeal that refuses to fade, even in the face of fatigue, and for ZAPs, zero-field scans, and the zen that comes only from years of learning and teaching.

Guess where in TMC ?

Answer on the last page

Through the Looking , Blue Panes of TMC

Rijushree Saha
JR, Radiation Oncology

Every doctor enters this institution with hope in their eyes, fire in the belly, and grit and determination. They prepare themselves to treat the dreadful disease of cancer on an everyday basis. In this crucial journey, innumerable teachers — in the form of patients, residents, or professors — shape them into what they become in the future. What remains integral is their passion to perform, drive to learn, and eternal compassion towards humanity. Here is a fictional narrative based on multiple experiences, sketching the journey of a resident as she grows up within these walls of TMH. We witness her growth in character and likewise fathom that some things always remain the same.

It was the year 1995 when she first entered the modest hospital building located in the busy heart of Mumbai. Her two ponytails swung over her oiled hair, framing a shining moonlike face, as she stumbled on the cracked tile at the entrance of the new Golden Jubilee Block. She adjusted her well-ironed white apron with enthusiasm when an old man flashed his ID card with a mouth full of saliva in front of her. He asked in a husky voice, “Aho, madam, hey OPD madhe kase jayche (how do I reach this OPD)?” It was her first day of residency. She got nervous on sighting the twisted Ryle’s tube in his hand but nodded, “Mi tikde challe aahe. Aapanhi majhyasobat chala. (I am going the same way. Walk with me).”

When she finally located the OPD on the 1st floor to report, bringing along the man with his worried son, she peeped sheepishly through the glass of the wooden door. She saw a tall, sleek guy in his apron with a thousand creases, sweating it out examining a tobacco-stained patient’s mouth. He looked like a senior resident. She sighed with relief as she pushed open the door, asking a bit loudly, “Ma’am didn’t come, no?” He just nodded a questionable “no” as he did not know her. He carefully wrote his oral examination findings with a blue ink pen, neatly drawing the diagram as Dr. KD would have preferred. She made the old man and his son wait outside as she asked him, “I think he requires our help.”

Once acquainted with each other, they made the old man sit on the steel stool in front of them. Writing a prescription, he told the son to get it from the ground floor. As they examined the skin, she saw a black discolouration with some charring on the left side of the neck. He examined the oral cavity, teaching her how to report the findings as she noted them down this time. “Do you know how to report mucositis?” he asked. She faintly remembered

a WHO scale as she saw the ulcers. “Is this Grade III?” Impressed by her knowledge but hiding it, he said, “Yes, but there is a different scale now which we use called RTOG. According to that, it would be Grade IV. Read it and you must write and show it to me tomorrow.” She frowned a little but took a note in her diary, all the while wondering where ma’am was.

With a brand-new Ryle’s tube in hand, he asked her, “Have you done an insertion before?” Trying to recollect her undergraduate days, she said, “Yes, a few.” Seeing a buzzing line of patients in front of him, he said with a sigh of relief, “Why don’t you try this then?” She was a bit hesitant at first but wanted to show her confidence. This was worth the shot to prove her skill.

She told the old man to take deep breaths as she applied jelly on the tip of the nasogastric tube. With a dangling stethoscope around her neck, the nurse assisted her as she inserted the tube slowly and steadily. She could feel resistance and murmured, “This is getting stuck…” He replied swiftly, “This is a treated case of carcinoma hypopharynx. The insertion would be a bit rough. Do you know how we define the hypopharynx?” Sweating it out, she felt irritated and amused at the same time. All she could hear was the rattling speed of the fan in the background. The old man started gasping for breath.

“Please stop there. Who is this?” a woman in her late fifties in a saree approached her. Her streaks of grey hair, a testament to her experience, framed a sharp sight that pointed to her clinical acumen — but right now, her eyes were filled with rage. “What do you think you are doing, madam? Don’t you see the man gasping for breath?” Looking at the senior resident, she said, “Why are you not supervising this? Don’t you think we should evaluate this more before blindly changing the tube? How many months have you been here?” She realized that ma’am had finally arrived.

Both stood in silence as Dr. KD asked the nurse to connect the monitor to check the vitals, muttering to herself. The SpO showed 93% with a low blood pressure of 100/80 mmHg. “This patient requires thorough hydration. We require blood tests and electrolytes done for him. First, let his vitals stabilize and get him admitted in our ward in the Annexe. And please start him on oxygen. And madam, observe first. Don’t rush to do things.”

While he got busy with the shifting and admission work, the professor started her routine OPDs as she stood silently behind. Her face drooped; she had wanted to create a good impression of herself. She had always been an active and bubbly intern, but right now she felt dejected and ignored in this busy environment. She wanted to prove herself but was unable to understand how to act. She silently opened her diary, glancing at her notes, when she saw the printed date of the day.

The OPD was about to wind up as Dr. KD saw her last patient. Although subtly, she couldn’t help but notice the dedication of her new resident. As the professor was about to leave, she said in a soft voice now, “Thank you and sorry, ma’am… and Happy Teacher’s Day...” She smiled mildly at Dr. KD, filled with hope in her innocent eyes. The professor was taken by surprise. Dr. KD couldn’t ignore this. This was unexpected. She smiled finally and said to her, “Oh really. Thank you… I hope you learnt something. Treat the patient also, not just the problem.” Her senior resident was back by that time, finishing the formalities of the admission. In a joyful mood now, the professor asked, “Hey hero, do you want to say something?” Although he couldn’t help but smile, he said in a nervous tone, “Yes ma’am, I have admitted the patient. Will show you in the rounds tomorrow morning, ma’am.” She looked at the senior nurse and exclaimed in a loud voice, “Aajkal ke residents na... abhi Teacher’s Day bol rahi hain...”

Thirty years passed by. She soon grew up to see this modest hospital develop into a globally renowned cancer centre. Her hair was now a bit grey with streaks of colour. Decked up in her cotton salwar kurtas, residents would fear and respect her for her clinical acumen and punctuality. She kept a blue ink pen to write on files, but now she dictated notes to her senior resident who typed them in the EMR. She too liked diagrams — still drawing them as Dr. KD preferred. Her own private OPD was now in the HBB block, a new towering building with blue glass built in 2011. It provided beautiful views of Mumbai, especially during rains, which she heartily enjoyed with Rajwadi special masala chai.

In her busy OPD one day, amid the background drum rolls on the fifth day of the Ganesh Chaturthi immersions, she grumbled, "These days they will do noise pollution. How am I supposed to see patients in this noise? As if these festivals weren't there before!" Her residents had gotten used to this and continued their work as usual — some typing their new workups while the juniors looked at the CT scans on the hospital PACS as she questioned their anatomy. There were forms now for filling the toxicity grades she assessed for trials, filled by her trial coordinators. Her new junior resident stood in a corner as she was instructed to observe.

Suddenly, she heard a loud noise outside. Her inquisitive and helpful nature prompted her to immediately stand up from her easy chair and go outside her OPD. An old man had fallen down walking towards her OPD. She instructed her senior resident to get his vitals checked immediately, although he looked stable now.

Her new junior resident had not come out. She wondered about these Gen Z doctors. Once she stormed into the OPD she said, "Are you a human being? Don't you think you should have come out?" The new junior resident's face drooped. She did not think she was required there; instead, she was trying to remember an answer on lymph node drainage asked to her five minutes back. She had peeped out, though, sheepishly, and ensured everything was under control. She immediately said, "Sorry, ma'am…"

For days after, the junior remained subdued. The senior doctor, half-amused and half-exasperated, thought to herself, They have Google now; we had to write answers by hand.

That Friday, as she wrapped up her OPD and boarded the bus to ACTREC, her phone buzzed. A WhatsApp message from the same junior lit up the screen: Happy Teacher's Day, ma'am. Sorry about the other day. She couldn't help but smile, remembering her own first Teacher's Day with Dr. KD — the nervousness, the scolding, and the unexpected kindness that stayed with her for decades. Turning to her colleague, once her senior resident, she said warmly, "Aajkal ke residents na… abhi Teacher's Day bol rahi hain." He chuckled knowingly. "Yes. Some things never change." As the bus rolled forward, she thought of her teacher, and realized that the lessons once passed down through those blue glass panes of TM were now being passed on through her.

Dr. Rijushree Saha,
Junior Resident
Department of Radiation Oncology

A Word about the Author

I have been a resident for the last two years in TMH. Here I present to you my imaginative short story echoing unforgettable experiences from the halls of my department. I sometimes write on weekends (if we are not busy with our residency!). Follow me @the_clinical_oncologist for more such anecdotes based on my experiences in oncology.

What makes a true teacher?

Akshay Baheti
Professor, Radiodiagnosis

No one can forget Steve Jobs masterful launch of the iPhone. "Today, we're introducing three revolutionary products" he said – "a widescreen iPod with touch controls, a revolutionary mobile phone, and a breakthrough internet communications device." Jobs then repeated the three products a few times: "An iPod, a phone, an internet communicator…". And then he made the revelation "Are you getting it? These are not three separate devices. This is one device. And we are calling it iPhone."

It was an iconic moment. The iPhone - three products rolled into one - changed everything in the cell phone industry. While perhaps not the best parallel, I remembered it while writing this article. I am writing on a similar theme – an all-important 'product' which is actually three rolled into one – the teacher.

Teaching

Across most of school and junior college (high school), my concept of a teacher was simply the one who teaches or gives instruction. There were average teachers, who couldn't hold our attention due to whatever reason – deficiency in content, enthusiasm, or aura; good teachers, who usually gave excellent exam-oriented lectures and clarified concepts without making us feel sleepy; and a handful of extraordinary teachers, whose lectures I truly

looked forward to because they inspired me to think and do beyond what was in the textbooks. Drona is probably the quintessential Indian example of an exceptional teacher.

I got exposed to some extraordinary teachers during my medical training. My alma mater KEM had a lot of excellent teachers who demonstrated both theoretical and practical acumen, patiently simplified concepts for us, answered queries, and often went out of their way to take clinics and teach. I have fond memories and anecdotes of many a great teacher which still feel as fresh as yesterday.

Many of the basics and good practices ingrained in me as a doctor are thanks to my phenomenal teachers, and I remain perennially indebted to them for that. However, once you complete medical training, you realize that becoming an MD is only the beginning. There are innumerable questions and doubts hovering in your mind about what to do next, and how. I experienced the same, and I realized that I needed someone more than a teacher – I needed a guide, or a mentor.

Mentoring

The Oxford dictionary meaning of 'mentor' is 'an experienced person who advises and helps somebody with less experience over a period of time.' But the best definition of mentor that I have come across is by Suzanne Koven, who defines a true mentor as someone who has more imagination about you than you have about yourself, i.e. s/he recognizes your potential better than yourself.

After my MD was over, I was confused about doing a fellowship abroad vs working in a good institute in Mumbai for further training. I wasn't sure what would be the right path for me. After a lot of agitating and asking around, I decided to approach my HOD Dr Ravi Ramakantan. He asked me to give him a few days to think, ask around, and get back. After two days, he called me and said in a single line – "Akshay, you should go to the US for further training". And that did the trick. I felt that I did not need to ponder about any longer. I immediately started preparing for USMLE, and can now state with certainty that it was the perfect choice for me. That probably is the highest level of mentorship – someone whom you can trust blindly to give you appropriate advice. Mahabharat again illustrates the perfect mentor – Krishna. While never their teacher, he was a mentor to Arjun and the entire Pandav clan, and inspired them to victory. The Gita and the 18-day battle that ensued is the ultimate example of the mentee Arjun religiously following the mentor Krishna's advice.

The US has in a sense institutionalized mentorship. While the concept of mentorship was never formally introduced to me during my medical training in India, it is common parlance over there. Mentorship is something expected out of every academic, and which they do with pride and happiness. My three years in the US led me to firsthand experience the advantages of having great mentors, who truly pushed me beyond my boundaries. They often gave tremendous opportunities and guidance, be it writing Radiology Clinics articles, making me a reviewer and later journal editor, or even inviting me for treks or home for dinner. I often wondered whether I really deserved them, only to subsequently be able to form strong bonds with them and successfully fulfil and often exceed expectations under their guidance.

After I returned back to India, I have tried my best to be a good teacher and mentor. Each is an extremely fulfilling role. However, while I felt privileged to have the opportunity to be both, I still felt something lacking in terms of impact. I started realizing the limitations of this two pronged approach – it wasn't the magic bullet I had expected it to be. Interactive teaching is time consuming while teaching larger audiences in didactic talks can only go so far. Vis-à-vis mentorship, it can only happen if someone approaches you, something not still routine in India as the concept of approaching mentors remains foreign to many. Furthermore, both the mentor and the mentee need to connect well and give time to each other; the relationship should not just be transactional. And the scope of mentorship is

usually limited to professional and academic practice – what to do next, what research project to work on etc.

One product was still missing, so to speak. Or rather, it wasn't recognized by me.

Role-modelling

Along the years, as I reflected over my training across different institutes and at Tata as faculty, I slowly recognized this third overarching component. To make it easier to illustrate, let me give my own example. I work as an oncoradiologist for patients with essentially three types of cancers – GI / HPB, gynecological and pediatric tumors. I have been lucky to have had many expert teachers who have taught me. However, most of the people who have shaped me or inspired me to reach this position did not really teach me anything closely related to what I currently practice. Ravi Sir taught me plain radiographs and fluoroscopy. Dr Bhavin Jankharia taught Chest and MSK. I rarely discuss my areas of focus when I meet my US faculty and mentors at RSNA. Similarly, many of my Tata colleagues and senior faculty I get inspiration from are from outside my department, and many do not even treat the cancers focus on (they may be working in surgery, medical oncology or nuclear medicine for example).

And yet, I believe that I owe most to these people. Not because of what they taught me or what they saw in me, but because of what I saw in them. They became my role models to emulate. More than radiology, what I learnt from them was sincerity and work ethic, demonstrating kindness and approachability to trainees, and humility. Across the years, many of my mannerisms - the way I interact with other radiologists and oncologists, my focus over the language of a radiology report, are me consciously or unconsciously modelling my behaviour and attitude on such role models. On the other hand, we have all seen excellent doctors and teachers who however lack compassion to patients or who are petty or condescending to colleagues and juniors in the department; we do not remember them with the same level of fondness or reverence despite their good clinical acumen and teaching skills. This is because they were bad role models.

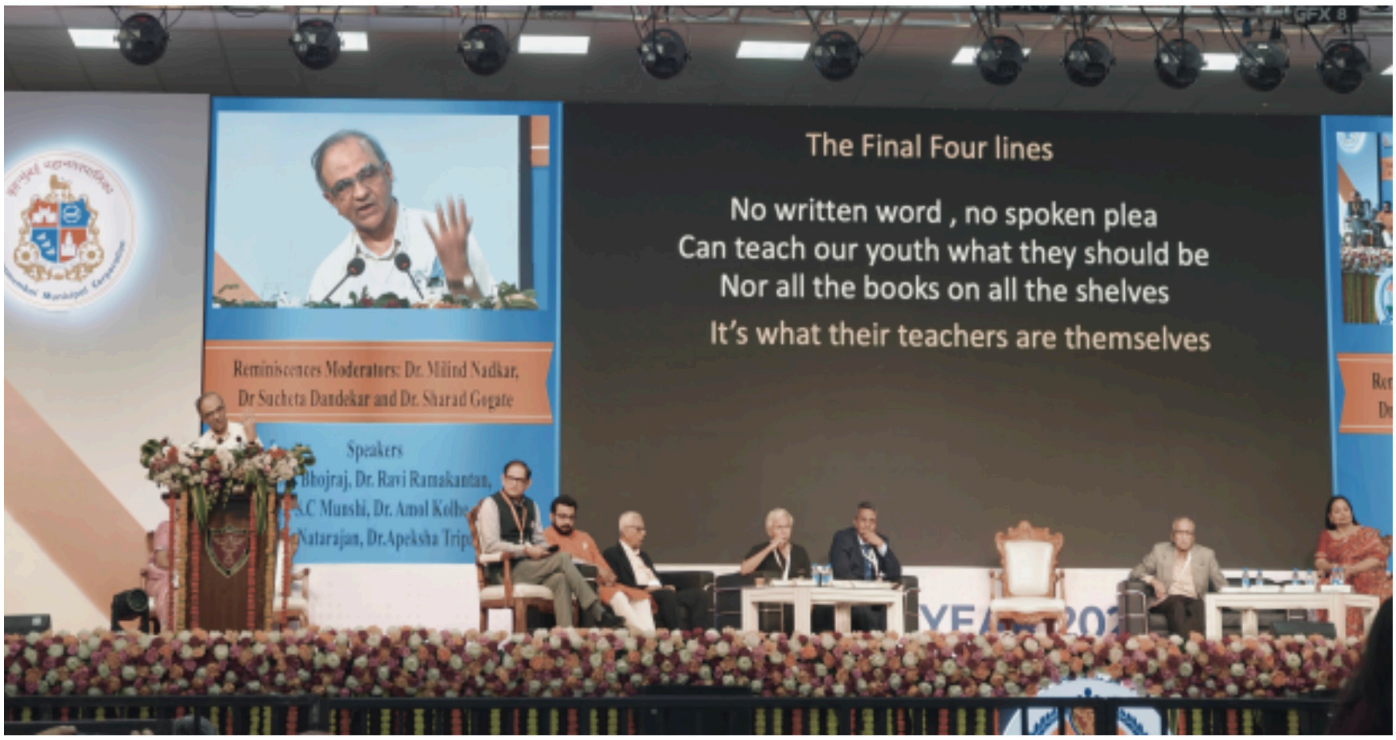
Role-modelling is probably the most crucial of the three elements to create good doctors, and more importantly, good human beings. While our immediate focus during training remains on gaining direct skills and knowledge, we also subconsciously imbibe the personalities and ethos of the teachers around us. In a sense, the direct teaching impacts our left brain while role-modelling moulds our right brain.

Steven Spielberg's brilliant 'Saving Private Ryan' involves Tom Hanks eventually dying while trying to save Matt Damon (Private Ryan) in World War II. It ends with a moving scene of an old Matt Damon at Hanks' grave, hoping that he had led a good life and had earned the sacrifices made by others to get him back home alive. A good role model will make you feel the same when you meet him/her years later. You will feel the desperate urge to earn his or her nod of approval at how you have practiced medicine and lived your life.

I started with an obtuse allegory to the iPhone. Let me end with a more relatable one. The number three is holy in Indian mythology. The Trinity or Trimurti take care of the world – Brahma, Vishnu and Mahesh. During the Kumbh, the Triveni Sangam or the confluence of Ganga, Yamuna and the mythical Saraswati is a holy place, with a dip in it sufficient to wash off all sins. The same way, someone who successfully teaches, mentors and becomes a good role model attains a sacred place in the lives of many trainees as a true teacher – one who shaped their knowledge, career, and character.

I end with the lines by an anonymous poet quoted by Ravi Sir recently when he spoke during the KEM Centenary celebrations, which illustrate the power of our actions and our behaviour.

'No written word, no spoken plea,
Can teach our youth what they should do,
Nor all the books on all the shelves,
It's what their teachers are themselves'



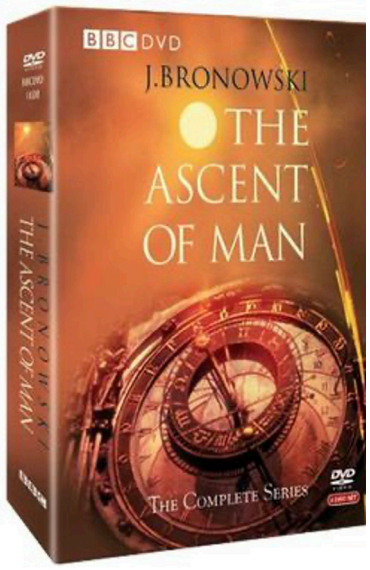
PS: The term 'teacher' itself is perhaps limited in scope – it by definition is simply someone who teaches. It thus doesn't allow us to imagine its scope, and leaves us to figure it out slowly by ourselves. The Hindi word guru is far more appropriate – it conveys the enormity and the impact of being a teacher much better; I cannot find a similar equivalent in English.

PPS: This article is reproduced from the author's blog. You can access more of his articles at https://mangomanindia.substack.com/

From Dr Mittra's Shelf - A Guide to Good Reads

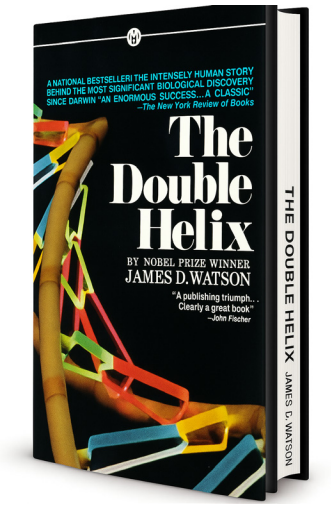
Dr Indraneel Mitra
Professor Emeritus

The Ascent of Man - Jacob Bronowski



This book by Jacob Bronowski - a Polish-British mathematician and historian of science - is based on a 13 part BBC documentary series first televised in 1973. His presentation was so captivating that nearly half of Britain (me included) would be glued to the TV every Saturday at 9 p.m. He subsequently produced the book "The Ascent of Man" based on the television series which has sold millions of copies. Bronowski traces the development of human society through our understanding of science. Bronowski discusses human invention from the flint tool to geometry, agriculture to genetics, and from alchemy to the theory of relativity, showing how they are expressions of our ability to understand and control nature. The book is highly informative and should be read by all who are interested in the evolution of science.

The Double Helix - James Watson

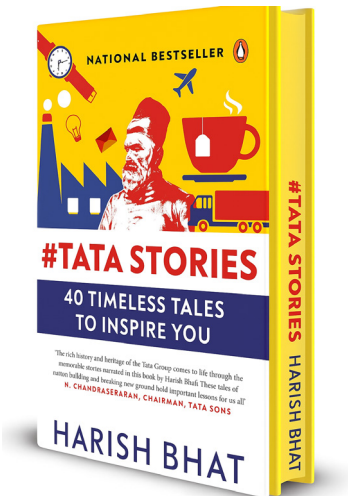


The Double Helix was written in 1968 by James Watson, who together with Francis Crick, first described the structure of DNA in a paper in Nature in 1953. Their discovery led to a Nobel Prize awarded to Watson, Crick and Wilkins in 1962. The book is a personal account of the convoluted process through which the structure of DNA was discovered. The journey was driven by ambition, secrecy, intrigue, stealth and inter-continental rivalry with Linus Pauling working at California Institute of Technology. The book tells us how the X-ray diffraction patterns discovered by Rosalind Franklin, ultimately, after many false starts, gave Watson and Crick the idea of the helical structure of DNA. Unfortunately, Rosalind Franklin died of ovarian cancer in 1958 and the Nobel Prize was awarded to her boss Maurice Wilkins under which she worked and with whom she had a strained professional relationship.

Dr Dushyant Jaiswal
Professor, Plastic and Reconstructive Surgery

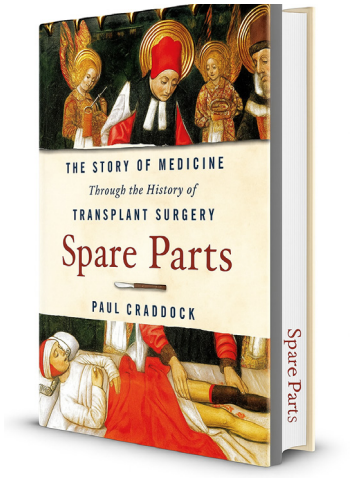
Topical Picks - Dr Dushyant Jaiswal

Tata Stories – 40 timeless stories to inspire you - Harish Bhat



Did you know that the Tata 'Sumo' vehicle was named after a Tata employee, or that Titan is the original 'Make in India' success story, or that the Tatas once built a supercomputer?! Numerous amazing short stories from the history of Tata group are crisply narrated in this book by an insider who served on the board of the Tatas. We, the employees of TMC , are often asked whether we work under the Tata corporate conglomerate. We end up explaining we are 'Tata' but not really 'Tata – Tata'. This book will make you realise how much of the real Tata philosophy still pervades our institute, from 'unending resilience and hard work' to 'compassionate capitalism' to 'grooming leaders' to 'service to the nation' to 'institution building' and much more. As a bonus, this book is perfect for children as well!

Spare Parts – Story of medicine through the history of transplant surgery – Paul Cradock



Spare Parts is filled with fascinating anecdotes and stories that trace the evolution of transplant surgery in the many unexpected and captivating ways. For example, it was the arrogant disdain of a junior resident for his faculty who were not able to suture the portal vein of the French prime minister which ignited the spark which led to the birth of vascular surgery. The same resident then learnt humility when a master embroiderer gave him insights into why his techniques were not working initially! He then went on to win the Nobel prize for vascular suturing, also opening doors to organ transplant surgery.

And that's just one story.

Teeth transplantation, for instance, has a surprisingly rich and amusing history — just Google Waterloo teeth to get a taste!

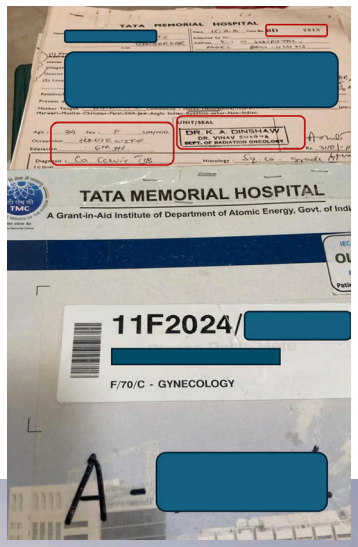
The first successful kidney transplant wasn't performed by a urologist, but by a plastic surgeon in his free time! He, too, went on to win a Nobel Prize.

You'll also discover the story behind how grafting in plants inspired organ transplants!

For such amazing stories of medical history and human transplantation, pick up Spare Parts and read it in your spare time without fail!

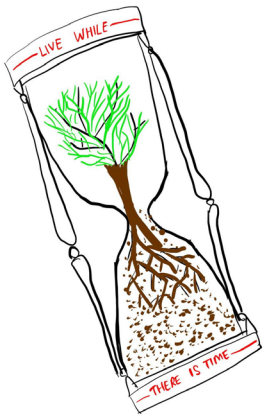
In Service in Life and Beyond...

Dr Jaya Ghosh
Professor, Medical Oncology



Patient Mrs. S was treated for Carcinoma Cervix Stage IIB with radical radiotherapy in 1991 by Dr Ketayun Dinshaw.

She developed a second primary Squamous Cell Carcinoma Vulva in 2024 and was treated with Proton therapy at the Ketayun A Dinshaw Shodhika!



Time Machine

Tata Memorial Hospital Tissue Bank

Introduction

The concept of replacing diseased or damaged body parts has existed for thousands of years. Just as organs are donated and transplanted, human tissues can also be donated by deceased and living donors to restore function and relieve suffering. A tissue bank is a registered facility dedicated to the recovery, screening, processing, storage, and distribution of human tissues for research and therapeutic purposes. The primary goal of a tissue bank is to provide safe, high-quality grafts; hence, all donors are thoroughly screened for transmissible diseases before tissues are released for clinical use.

Establishment of the TMH Tissue Bank

As part of the IAEA/RCA program to promote the use of ionizing radiation for sterilization of biological tissues in Asia and the Pacific region, the Department of Atomic Energy (DAE), Government of India, encouraged the setting up of a tissue bank at the Tata Memorial Hospital (TMH), Mumbai.

The TMH Tissue Bank was established in 1988 under the leadership of Dr. N.M. Kavarana, Head of the Department of Plastic Surgery, and formally inaugurated in 1989. Selected by the IAEA for this pioneering initiative, it became India's first tissue bank and introduced radiation-sterilized biological tissues as a safe and cost-effective transplantation option.

At the time, little was known about tissue banking globally, with the field still evolving in terms of norms and regulations. Dr. A. Gajiwala was appointed to start and establish the TMH Tissue Bank. She was deputed to attend the IAEA/RCA Regional Workshop on Radiation Sterilization of Human Tissues and maintained regular contact with international experts to develop

protocols. The IAEA supported training through multiple workshops and, along with the National University of Singapore, initiated an International Diploma in Tissue Banking, which continues to build regional expertise. Prof. Ajay Puri, the current head of the TMH Tissue Bank, earned his diploma in 2005 from the National University of Singapore.

Early Challenges and Growth : In its early years, the Tissue Bank faced two significant hurdles:

Creating awareness about tissue donation : since tissues that could have been donated were often discarded.

Building confidence among surgeons : to trust processed grafts as safe and clinically effective.

Through persistent educational efforts, word-of-mouth campaigns, and presentation of award-winning clinical papers at conferences, TMH gradually established credibility. Peer-reviewed publications further reinforced the utility of these grafts, and acceptance steadily grew.

Regulatory Framework

Procurement of tissue for transplantation is governed by the **Transplantation of Human Organs Act, 1994 (THOA)**, originally designed to regulate organ donation (kidney, heart, etc.). TMH Tissue Bank was first registered in 2001 with the Maharashtra State Health Services. Registration is renewed every five years after inspection by an expert committee. The bank follows internationally accepted ethical and scientific guidelines, ensuring informed consent and patient confidentiality at all stages.

Production and Utilization of Allografts

Initially, the TMH Tissue Bank produced amnion grafts as biological dressings. With the establishment of a dedicated orthopedic oncology service, the bank expanded into bone allografts, and over the decades, production diversified to meet rising demand across multiple specialties—orthopedics, oncology, neurosurgery, oral and maxillofacial surgery, and plastic surgery.

Type of allograft and allograft production over the last few decades

Type of Allograft	Introduced in Year/ Allograft production	Year/Allograft production	Year/Allograft production	Year/Allograft production
Amnion	1989/446	2007/1108	2017/2234	2024/2022
Chorion	2008/02	2012/937	2018/2664	2022/2573
Femoral Head	1991/02	2007/264	2017/501	2022/735
Tibial Slice	2003/95	2007/227	2017/561	2022/1146
Strut	2004/02	2015/15	2022/15	2024/30
Bone Granules	1992/12	2007/145	2017/1568	2024/2128

Since inception, the TMH Tissue Bank has produced over 1.7 lakh grafts, benefiting patients not only at TMH but also in 650+ hospitals nationwide. Importantly, TMH grafts are supplied at subsidized rates, ensuring accessibility compared to expensive international alternatives.

Recognition and Milestones

- 2004 – ISO 9001:2000 certification for its quality management system.
- 2005 – Featured in the Limca Book of Records for pioneering radiation-sterilized allografts.
- 2024 – Recognized as the Best Tissue Bank on Indian Organ Donation Day by ROTTO-SOTTO (Regional cum State Organ and Tissue Transplant Organisation).

Training, Research, and Collaborations

Beyond graft supply, the TMH Tissue Bank has played a national leadership role in capacity-building and research. It has helped spread awareness about tissue donation. It regularly trains national and international observers and has helped establishment of similar facilities in the country by giving hands-on training in basic tissue processing procedures. In 1998, TMH tissue bank helped initiate a tissue bank at the Defense Laboratory, Jodhpur. The TMH Tissue Bank has collaborated with numerous institutes of national and international repute such as IAEA, IIT Mumbai, IIT Ropar etc. to understand the clinical efficacy and properties of tissue allograft. Besides aiding in many dissertations by dental students, the TMH tissue bank is the recipient of a Department of Science and Technology grant for the proposal "Processing of waste placental tissue from maternity wards into regenerative tissue grafts for non-healing wounds and other clinical applications" in collaboration with IIT Ropar.

Conclusion

Tissue banks are indispensable to modern healthcare, providing safe, reliable grafts for reconstruction and restoring quality of life. The Tata Memorial Hospital Tissue Bank, as India's first and most experienced facility, has remained true to its mission—supplying indigenous, cost-effective, high-quality allografts while driving awareness, training, and research. With over three decades of service, it continues to stand as a model of innovation, accessibility, and clinical excellence in tissue banking.

Answer to the photo quiz: ACTREC, Navi Mumbai. Can someone send us the background story?
Photo Credit : Dr Revathy Krishnamurthy., Radiation Oncology