Group practice in Ophthalmology - A primer

Editor : **Dr Rajiv Sukumaran**

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Meet the Challenge - A Group Practice Way

Dr Babu Krishnakumar
President KSOS

Dreams rarely come true. Group Practice is a dream we had included as a major project of KSOS for the year 2020 to 2021. With this book 'Group Practice in Ophthalmology – A Primer' and multiple CMEs on group practice we have incorporated our dream to the minds of ophthalmologists who are desirous to prove their determination in the world of tomorrow.

Everything from working space, gadgets to manpower is getting costlier day by day. Solo ophthalmology practice will decline over time. Group Practice is going to be the password for future. In the world of competitive practice, a newcomer or those who want freedom can depend on Group Practice. This modality is independent and lovably dependent too. The group including you are the masters who formulate, dictate and execute your ideas that are well thought out, discussed to ultimate depths and accepted whole heartedly. Under one roof you share your consulting space, time, days, workforce, instruments and machines, theatre, pharmacy and laboratory. Shouldering work and leisure strengthen the bonds of group. Group Practice can spread out from one speciality to multi-speciality and from single location to locations far and wide. Transparency with patient dealing to revenue sharing relieves much of your tension and apprehensions in Group Practice way. The concept introduced by Mayo brothers to the new world is gaining more acceptance as the time advances.

We have conducted 3 dedicated CMEs for the interested persons to make the subject easy to decipher. Our efforts were successful is highlighted by the attendance and continued browsing at YouTube on same CMEs. Questions were hurled repeatedly and were answered appropriately.

This book on group practice brought out by scientific committee of KSOS will remain a benchmark for ever as the authors happen to be authorities on what they have contributed. You can depend totally on the ideas and methods we suggest here as all of them are time tested and honoured.

From the start onwards Dr Rajiv Sukumaran the efficient, enthusiastic and smart Chairman of Scientific Committee of KSOS kept the topic dear to him and escorted it to new directions with the CMEs he himself has authored, compiled and presented. This book 'Group Practice in Ophthalmology – A Primer' brought out under scientific committee series is the crowning glory for KSOS and is the brain child of Dr Rajiv Sukumaran. The book is a manifestation of Dr Rajiv's wisdom.

Editorial

Dr Rajiv Sukumaran
Chairman, Scientific Committee 2019-21, KSOS

Group practice is defined as the cooperative practice of Medicine by a group of physicians, each of whom as a rule specializes in some particular field, such a group often shares a common suite of consulting rooms, laboratories, staff and equipments. In short it is a group of doctors with a common vision who share premises and other resources.

Although the Mayo brothers have been recognized as the Father of group practice of Medicine, Dr.William J. Mayo is reported to have confessed that, 'if we were we did not know it.' The brothers established Mayo Clinic as a solution to their daily challenges of their rapidly growing surgical practice by associating with specialists whose expertise would enhance their surgical capabilities. The concept caught up late in India but was not so popular in Kerala, where majority opted for service in a government or Private hospital or remain Solo. Very few have succeeded in establishing proprietary firms.

With Corporates eating up small and medium hospitals Solo practice of late, is facing a threat to its existence. Complex Government regulations, expensive equipments that are much needed to keep abreast with the changing times, need to get empanelled in Insurance schemes and get accredited with NABH, JCI etc are all beyond the reach of Solo practitioners. By the option of sharing the cost and administrative responsibilities Group practice comes to their help in such situations. This will also give them more quality time for family. Patients are also going to benefit from this. Although the strength of Group practice is in numbers, the alliance won't last if there is conflict of interest among the partners.

The various models of group practice, budgeting options, Statutory needs, points to be considered while building the infrastructure and purchasing equipments, recruiting the support staff and enhancing the footfalls by ethical marketing are all discussed very well in various chapters.

I am sure this CME update by KSOS, although not a comprehensive treatise on the subject, will be a useful primer to the aspirants who are eager to build a professional career by adopting cooperative medical practice.

Reference:

Kash B, Tan D. Physician Group Practice Trends: A Comprehensive Review. J Hosp Med Manage. 2016, 2:1.

Guest Editorial

Dr Mahesh G
Hon General Secretary, KSOS

Group practices have existed for over 100 years with one of the first groups set up by the Mayo brothers in the mid-1880s which later became a centre of excellence. Sizes of group practices vary dramatically, from 2 physicians to over 100 physicians, and there is no standard definition of what defines a group. Many papers have been published on group practice formation assessing various advantages and disadvantages for patients, physicians and healthcare systems. The economic benefits of these groups and the improvements in service provision to patients,barriers to the formation of group practices or conflicts that can result from group practices etc. are known. Patient care can be significantly altered by the formation of group practices. Advantages include increased income, quality of life, satisfaction and decreased physician burnout.

A systematic review published in 2013 assessed the effectiveness of group versus solo practice among general practitioners and demonstrated a positive association between group practices and clinical processes, physicians' opinions and innovation, but did not observe any effect for patient measures. [1]

A group practice structure has many advantages for patients and physicians alike. Although the data are somewhat limited for patients compared with physicians, a *Scoping review* has shown that there is a generally positive patient experience with some evidence of improved quality of care. There is also an increase in physician satisfaction and quality of life in groups that function well with compatible personalities. [2]

In summary, group practices improve patient satisfaction and experience, patient quality of care, physician quality of life, satisfaction and burnout. Also, group practices improve physician competency leading to higher incomes for physicians and finally it may help reduce costs within healthcare systems

This book by KSOS is a bold step to help our members establish group practice in an easy way. It has most of the details they would like to know. I am sure this will help each ophthalmologist and will be appreciated across the country.

Reference:

[1] *Damiani G, Silvestrini G, Federico B, et al. A systematic review on the effectiveness of group versus single-handed practice. Health Policy 2013; 113:180–7.*

[2] *Zwiep T, Ahn S(Hilalion), Brehaut J, et al. Group practice impacts on patients, physicians and healthcare systems: a scoping review. BMJ Open 2021;1: e041579. doi:10.1136/bmjopen-2020-041579*

ACKNOWLEDGEMENTS

When our President Dr Babu Krishnakumar came up with his project to help people interested in group practice, I was a bit skeptical. As it unveiled, I found it to be a very apt topic in the current scenario of difficulty in stand-alone practice. We short listed a few Ophthalmologists who are into group practice with vast experience, a Chartered accountant and Hospital Consultant of immense experience. They contributed the chapters in the book. We sincerely thank all the authors for taking an extra effort and time to realise this venture.

I thank the KSOS Secretary Dr Mahesh G, for suggesting to make this a CME series of KSOS and giving me all support.

This book was formatted, designed and printed by Thankam Printers, Karunagappally. I owe my sincere thanks to them also.

I owe immense gratitude to Dr S Sasikumar, Past President KSOS, who has helped us in editing. I am grateful to all members and Executive committee of Kerala Society of Ophthalmic Surgeons, especially Dr Babu Krishnakumar, President KSOS for all the encouragements they gave.

Dr Rajiv Sukumaran
Chairman Scientific Committee KSOS

Statutory Requirements, Budgeting & Financial Planning for a new Eye clinic/Hospital

CA R Sridhar, Sridhar & Co, Chartered Accountants, Trivandrum 23

I. Statutory Requirements for a new clinic/hospitals

The success of group practice commences with the right choice of Business format. Even though doctors are doing a profession when they collectively establish, it becomes a business and subject to more Laws and Practices governing business. Hence it is important to select a business organisation format from among the following.

- Proprietorship
- Partnership
- Limited Liability Partnership (LLP)
- Corporate
- Private Limited
- Public Limited
- Trust/Society

Pros & Cons of each of the above:-

1. Proprietorship

How could group practices be done in Proprietorship ? It is possible if one who establishes the clinic, engages other doctors on sharing basis without ownership rights. The proprietor is responsible for all investments, Loan taken and will be benefited with the net/resultant profit or may suffer loss and he/she is subject to the unlimited liability of the concern. In this system the growth may be restricted; other doctors may not be interested because they are not able to participate in the ownership/Profit.

2. Partnership

This form of business involves two or more person joining together, investing the agreed capital, sharing profit/ Loss in the agreed ratio and also subject to the unlimited liability created by the firm or any partner of the firm for the firm. Unlimited liability is a risky preposition since for settling the liability of the firm the personal assets can be attached. Partnerships can be registered or unregistered. Registration is done with Registrar of Firms, Thiruvananthapuram. The initial cost will be more than that of the proprietorship due to the formation procedures such as the preparation of partnership deed, the cost of Stamp Paper, etc.

3. Limited Liability Partnership (LLP)

In the last one decade, a new form of establishment has emerged to overcome the unlimited liability of Partners called Limited Liability Partnership (LLP). It is to be registered through the Registrar of Companies and is subject to the periodical filing of returns and follow ups. The main advantage of this format is that the partners of Limited Liability Partnerships are subject to the limitation of liability to the extend of amount they have agreed to bring in as partners. This is more structured than the format of partnership. The cost of establishing will be more than that of partnerships and also has more compliance cost. But this is the most preferred form of business for profession and can be practiced by sitting up in different part of the country under one banner.

4. Corporate

This is otherwise known as company format controlled by Companies Act 2013 and is having two types of companies called Private Limited Companies and Public Limited Companies. This is run by Board of Directors selected and approved by the Share holders.

A. Private Limited Companies

This type of corporates have some restrictions like restriction in the number of members from 2 to 200, restriction in transfer of Shares and restriction in offering shares to public. Cost of establishing Private Limited Companies and the compliance costs are more than that of the previous formats. The advantage of this format is that the shares of this company can be transferred with the consent of other shareholders through the approval of Board of Directors and also easier to admit new doctors as and when available /required.

B. Public Limited Company

Public Limited Companies is devoid of the three restrictions of Private Limited Companies viz. number of members minimum being 7 and maximum unlimited, shares are transferable and can be offered to public subject to Rules and Regulations. The compliance cost may be almost equal to that of Private Limited Companies, if not more.

5. Trust/Society

Most of the hospitals are run in this format. Persons doing it for Non-Profit motive form either a trust or a society. The doctors may be able to draw salary or fees; BUT will not be able to share the profit /Surplus.

II. Budgeting and financial Planning

The other consideration for establishing a group practice after deciding the format of business is about Budget and Financial Planning to enable the promoters to decide the requirement of capital to be brought in. It depends upon the following;

a) Preliminary Expenses – The cost of establishing the business.

b) Initial Fixed Cost - Building Advance/Ownership Cost/Interior Designs to suit the profession, the cost of machinery and the other cost of first-time establishments.

c) The operating Cost – As it is a business the flow of income from operation cannot be predicted/established for some period and hence the overhead cost which will be recurring in nature for certain period has to be brought in advance so that business can be run successfully till the Break-Even Point is achieved.

The total of the above three may be the total fund requirement for initial establishment and this can be brought in by owners after considering the availability of financial assistance /Loans and its cost of carrying.

III. Ethical and Systematic Operations

In group practice as different and varying people are joining together it is always advised to be highly ethical, systematic and corporate level operations so that the doctors are able to do their profession much better. In spite of higher cost of management and requirement of its regulatory compliance, better establishments will provide proper organization and peace of mind.

IV. Statutory Regulations

In group practice, under any of the formats specified above, different Acts come in to play and here we may talk about Acts which are all connected directly with your billing income, sharing income, incurring expenses and payment. There are so many regulations as per Income Tax Act like restriction in payment above certain limit in cash which is presently Rs. 10,000/-, expenses / payments in excess of specified limits to be made only after deducting TDS, filing periodic return of TDS. Maintaining banking relations also plays a crucial role as more transactions will come under the bank operations through net banking. Most of your collections from patients may be in cash though you may be establishing collection through net banking/POS machine/payment gate ways/e-wallets. A well knowledgeable accountant is

a must to take care of and also to guide in such matters as non filing of returns on the above matters in due time will invite penalties. It is also to be known that no cash transaction above Rs. 2 Lakhs can be undertaken or take loans / advances or give loans / advances above Rs. 20,000 in cash.

Though GST is not applicable to doctors and hospitals, the exemption is available only to doctors who are practicing their profession directly through hospital. If they form a company without hospital and share their services through the company, GST may come in to play.

For asset purchase you have to financially plan with regard to availability of loan through mortgage/sharing of income through the manufactures/dealers of such machineries etc. The concern may have to take FC Registration or obtain IE Code for import of machinery which is a regular process once the business format is established.

It is a million dollar question, whether to invest your money or obtain Loan. This depends upon

a) The availability of money

b) The income/Interest generated by such money available

c) The availability of loan, the cost of such loan like interest, etc.

d) The projected repayment capacity through the projected income which has to be conservative.

Key issues which are to be kept in mind are;

1. The risk of being director under a company who is responsible for i) running the company as well as filing proper returns to Statutory Authorities, ii) format and maintain the business establishment, iii) filing of returns like TDS, Income Tax, GST and others on time.
2. Like key managerial person, doctors are key professional person and their time devoted to management may not be as productive as professional. But the role as key managerial personnel is more significant.
3. HR Department is very important – in addition to finding out and maintaining right professionals and activities it is important to register, pay and file PF, ESI and other statutory obligations under HR.

Conclusion

Last but not the least, in a group practice the success lies in the conduct of the profession in which you are the master. But it needs support of other professionals to establish/maintain and run the establishments like Chartered Accountants and other professionals, depending upon your requirements, for the smooth and successful group practice in any format discussed above. Planning and structuring it under proper professional advice is the corner stone.

(The above article is a general over view and is not a binding opinion that can be applied for all cases or circumstances. It is intended to provide only a general awareness and actions may be taken only after direct consultation with a professional)

Statutory licences for an Eye hospital

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The level of healthcare existing in our country varies with places. In some places people will have to travel very long distances to access medical care. Qualified healthcare personnel and facilities are disproportionately distributed in the rural and urban areas of the country. But the Govt has enacted laws from time to time to ensure quality of services to every part of the country and all healthcare institutions have to comply with these statutory requirements. The latest of them is the Clinical Establishment Act (CEA) 2010 which makes it mandatory for all clinical establishments to register with a view to prescribe the minimum standards of facilities and services provided by them. It is applicable to all kinds of clinical establishments from the Private and Public sectors of all recognized systems of medicine including single doctor clinics, except that run by Armed forces. From the very beginning the goal should be to get accreditation with NABH or similar bodies to improve the quality of services.

Essentially the basic licenses needed to establish a medical institution are the following

1. Building permit
2. Registration with Local Self Government Departments (LSGD) and CEA. Registration under CEA is exempted if it is NABH accredited
3. Consent from PCB
4. NOC from Kerala Fire & Rescue Services department
5. Power allocation from the Kerala State Electricity Board (KSEB) and Sanction from Electrical Inspectorate
6. PCPNDT Licence for B scan (**P**re-conception **P**renatal **D**iagnostic **T**echniques)

7. Registration with ESI and Provident Fund
8. PAN and GST registration
9. Drug licence to dispense drugs
10. Regn under Narcotic Drugs and Psychotropic substances (NDPS) Act to handle Morphine, Pethidine and Pentazocine.
11. Spirit licence for bulk purchase of Ethyl Alcohol
12. MOUs with agencies for outsourced services like Ambulance, BMW management and Dietary

Building Permit is essential to get all other licenses for the clinical establishment. Buildings are classified into 12 categories. Of these clinics/small hospitals can be easily started in a Medical category of building while it needs special permission like 'occupancy change' from the Government in commercial/ Residential type buildings.

One has to be aware of certain terminologies while planning a building, whether owned or rented.

*Floor Space Index (FSI)*is the total floor area of a building allowable in the area of the land.

$$\text{FSI} = \frac{\text{The total floor area}}{\text{Land area}}$$

$$\textit{Coverage} = \frac{\text{ground area covered by the building x 100}}{\text{Land area}}$$

Maximum coverage allowed is 50% for medical buildings. And maximum FSI allowed is 2.5 (varies with municipality, corporation, category of panchayath) These are statutory area restrictions for buildings corresponding to land area.

The FSI and Coverage vary with places. Higher limit values of FSI and coverage ensures optimum usage of land and proper design, subject to the condition that space for visitor's parking and setback are satisfied. If the FSI is high the total area of the building increases thereby providing better utilization of land.

For eg; if Hospital FSI is 2.5 and maximum permissible coverage is 50.

For a 1000 sq M land, building with floor area of 2500 sq M can be constructed. If coverage is 50, the maximum allowable built-up area at any floor (building foot print) is 500 sq M and you have to construct 5 floors

Setback is the minimum open space required around the building or structure to facilitate ease of access around the building.

The rules governing construction of buildings in India is the National Building Code (NBC) which is amended in States according to local needs. In Kerala the KMBR (Kerala Municipal Building Rules), KPBR (Kerala Panchayat Building

Rules) are followed.

Points to be considered while purchasing a land

- Adequate approach road
- Zoning. Easy in Commercial while cumbersome in Residential
- Availability of drainage
- Presence of Wetland. Area of Wetland will not be calculated in the land area available for construction
- Shape of the land. Plots with bizarre shapes will affect effective utilization of land
- Terrain. Single of multiple levels
- Availability of good water sources
- Presence of HT (High Tension) lines over the plot. This will restrict the building height
- CRZ (Coastal Regulation Zone). If the plot is in the CRZ restrictions will be there for construction.

At the outset one has to get a building permit from the LSGD before starting construction. Apply online to the Secretary with

- Building drawing
- Copy of registration of the concerned Architect/Engineer/Building designer/Town planner or Supervisor as the case may be
- Documents to prove ownership of the land
- Application fee

Initial No Objection Certificate (NOC) from Kerala Fire & Rescue Services department and consent to establish from Kerala Pollution Control Board (KPCB) for Building permit, subject to the area and height of the building.

If the total built up area, including area of existing building (if any) in the plot is more than 1500 sq M approval from District Town Planning Department is also necessary.

Once the project is complete

Get *occupancy certificate* by reapplying again with the completion plan by a registered engineer/Architect. Afterwards get a building number from revenue section and then remit building tax.

After getting a sanitary certificate from the health Inspector, one should apply for *Trade License and Paramedical licence* from LSGD. Trade License is a certificate issued by the local government like Panchayat, Municipality and Municipal Corporations. This is like a permission to do business in the local limits of concerned Local Self Government (LSGD).

In case of a rented building:

- Check the building number, tax receipt and occupancy certificate. Should be Commercial or Medical.
- Check for violations in construction- can be ruled out if one can get an approved completion drawing
- Better to go for a registered lease agreement
- Ensure adequate area for parking including those for handicapped persons as per building rules, Genset, Transformer and UPS
- Check Fire NOC and PCB certificate

Pollution Control Board

PCB is not just concerned about Biomedical Waste (BMW) alone. The establishment should have means to handle solid, liquid, gaseous wastes and sound pollution.

(I) Solid waste is mainly

(a) Municipal waste which can be managed by a country incinerator and composting

(b) Biohazardous waste which has to be burnt in a PCB approved diesel injected incinerator. Alternatively, one can enter into an MOU with PCB approved agencies which can handle BMW at a cost. In Kerala, Indian Medical Association has a project called IMAGE (IMA Goes Ecofriendly) which can collect and scientifically manage all BMW from empanelled organisations. Recently Kerala Enviro Infrastructure Ltd (KEIL) has also been approved by the PCB.

(ii) Liquid waste is sewage and sullage. Sewage Treatment Plant (STP) is mandatory for major hospitals while small establishments can manage with septic tank and soak pits. Neutralisation or disinfection tanks are required to treat waste from Laboratories

(iii) Gaseous waste and

(iv) Sound pollution in the health facility are mainly from the Genset which can be managed by appropriate high rise chimneys and sound insulators.

As regards the building permit, initially one has to get a *consent to establish* from the PCB by applying online with

- Building design
- Location map including buildings and water bodies within 100-meter radius
- Required fee. The fee is related to the cost of establishment

After completing the construction, reapply to get *consent to operate* from the PCB.

Electrical licences

With an electrical scheme drawing from a licensed contractor, building permit and Land Tax receipt one has to apply to the Electrical Inspectorate.

After work is completed, an engineer from the inspectorate inspects the Transformer, Panel board, earth pit, Genset, Lift etc.

Once the Inspectorate gives the Sanction order, apply to the Electricity Board for power allocation with building permit, Completion report, Sanction order from Electrical inspectorate and ownership certificate from LSGD.

If the connected load is more than 50 KVA, KSEB may advise a dedicated transformer to be installed for the building considering the present load in the locality under the KSEB transformer. If the facility install a transformer on its own and keep only one meter for the entire building, then it is considered as an HT (High Tension) consumer. Electricity charges are more economical for HT consumer than LT. More over the variations in the voltage will not affect us if we install a dedicated transformer for our own thus saving the life of generator, lift, UPS etc

The Genset should be of adequate capacity to give 100% backup so that all power consuming equipments and services like autoclave, air conditioner and Lift can work together if needed.

Fire Safety

The rules vary with the States. NBC gives guidelines to fire safety for all buildings. In Kerala buildings <15-meter height and < 1000 sqM are exempted from getting NOC from Kerala Fire & Rescue Services department.

Ease of doing business by Govt of Kerala

As per the amendment, the owners need to submit only a self-attested application along with a certificate from the architect or engineer who prepared the plan, to get fire clearance for buildings that are between 300 and 1,000 square metres in area and less than 15 metres high.

For regular Fire licence apply to the Fire Department with

- Land document
- Architect's drawing stamped by LSGD
- Fire escape plan
- Letter from LSGD

Lab and X ray

No separate licence is required if the Lab is part of the hospital. However, a neutralization pit should be provided to disinfect the effluents from the lab before discharging into the main drainage.

X ray units are not usually a part of stand-alone eye hospitals. If such a unit is there it has to be built as per the requirements to ward off harmful

radiations. The wall thickness should be min of 24 cm solid block. The license has to be sought from Atomic Energy Regulatory Board (AERB).

An Ophthalmic B scan cannot be used for sex determination of the foetus. But the PCPNDT Act (Pre-Conception Pre-Natal Diagnostic Techniques) mandates a licence for Ophthalmic B scan also which has to be taken from the District Medical Officer. However, the clause has been stayed by the court as of today

Pharmacy

An area of 110 sq. Ft is needed for the pharmacy. It should have a refrigerator with power backup and facility for temperature recording

If multiple drug outlets are set up like for Inpatients and Outpatients along with a Central drug store, separate licences are needed for each.

For this apply to the Drugs Controller in the District with

- Building licence
- Registration certificate of the Pharmacist (separate pharmacists for each drug dispensing outlets)
- Basic drawing of the plot and building
- NDPS licence should be taken from the State Excise Department and Drugs Controller
- If any hospital wants to buy Ethyl alcohol for disinfection purposes, in bulk at cheaper rates from the Government, they should get a Spirit licence from the State Excise Department

HR needs

- Human resource department should comply with the Labour rules enforced in the State. Registration for Employee State Insurance (ESI Act) and Provident fund (PF Act) are needed as per the prevailing rules.
- Labour rules necessitate payment of wages through the WPS Software (Wage Protection Scheme)

<u>Support Services</u>

- Small hospitals don't have to invest in services like Ambulance, Dietary, BMW management etc. These can be outsourced, but enter into an MOU with the agencies

<u>Financial requirements</u>

- Permanent Account Number (PAN) is a basic need.
- Goods and services tax (GST) registration also is mandatory
- Tax Deduction Account Number or Tax Collection Account Number(TAN)

Following is the list of requirements as mentioned in the Clinical Establishment Act that are to be complied by hospitals.

ANNEXURE 6

LIST OF LEGAL REQUIREMENTS

Below is the list of legal requirements to be complied with by a hospital as applicable by the local/state health authority (**all may not be applicable**):

Sl. No.	Name of Document	Valid From	Valid Till	Send for renewal by	Remark **(Expired/ valid/NA)**
1.	Registration under Nursing Home Act/ Medical Establishment Act				
2.	Bio-medical Waste Management Licenses				
	Authorization of HCO by PCB				
	MOU with Vendor				
3.	AERB Licenses (As per AERB regulations)				
4.	NOC from Fire Department				
5.	Ambulance				
	Commercial Vehicle Permit				
	Commercial Driver License				
	Pollution Control Licenses				
6.	Building Completion Licenses				
7.	Lift license for each lift				
8.	DG Set Approval for Commissioning*				
9.	Diesel Storage Licenses*				
10.	Retail and bulk drug license (pharmacy)				
11.	Food Safety Licenses*				
12.	Narcotic Drug Licenses*				
13.	Medical Gases Licenses/ Explosives Act*				
14.	Clinical Establishments and Registration (if applicable)				
15.	Blood Bank Licenses				
16.	MoU / agreement with outsourced human resource agencies as per				

17.	Spirit License				
18.	Electricity rules				
19.	Provident fund/ESI Act				
20.	MTP Act				
21.	PNDT Act				
22.	Sales Tax registration				
23.	PAN				
24.	No objection certificate under Pollution Control Act (Air/Water)				
25.	Arms Act, 1950 (if guards have weapons)				

* (as per regulations of State)

References:

- *Kerala Panchayat Building rules 2019 gazette notification dated 02/11/2019*
- *Kerala Municipality Building rules 2019 gazette notification dated 02/11/2019*
- *KSEB Circular-Installation of separate transformer dtd 17-10-2007*
- *TheClinical Establishments Registration & Regulation Act, 2010. ACT NO. 23 of 2010 [18th August, 2010.]*

Planning an Eye Hospital

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Introduction

There is a big difference between “architecture” and a mere building. There is no architecture if a building is without good ambience, safety and comfort. Hospitals or clinics should be designed as a building that heals rather than patient warehouses. The hospital spaces cannot be optimally utilised if the needs of the patients and other users are not holistically considered and visualized. The healthcare buildings should satisfy all of its stakeholders like patients and staff, public and owner.

For Patients, family and staff; it should be warm and friendly, safe, and stress reducing.

For the public; it should fit with the surroundings & enrich it and give a sense of belonging.

For the owner; it should be economical to build and operate, flexible and have future growth potentials, besides reflecting the vision and mission of the owner.

PRELIMINARY INVESTIGATIONS & PLANNING

A DPR (detailed project report) comprising patient & population survey of the area, probable departments, assessment of outpatient inflow, inpatient & recovery beds, number of operation theatre ,financial projections etc should be prepared.

Land requirement

Area of the Land required should be assessed based on the approximate area of the building. Approximate area of building can be assessed from DPR or enquiry at similar hospitals already functional and working smoothly. Consider the future expansion also.

$$\text{Land area} = \frac{\text{The total floor area}}{\text{FSI}}$$

For example, if we need a building of a total area of 1000 sqM, land area required is 1000/2.5 = 400 sqm (approx 10 cents) where 2.5 is the Floor Space Index (FSI) allowed by the government as per Kerala Municipality & Panchayat Building rule. FSI may slightly vary between municipality and panchayat.

Practical tip: purchase extra land considering the other rules like setback, coverage and number of parking. Also consider the future expansion of the building

Required water source, road access to plot, electricity substation & its capacity, survey of plot, soil exploration, wind velocity direction, legal matters etc are also to be considered. Consult an architect or registered civil engineer at this time for legal and technical advice.

Appointment of ARCHITECT or ENGINEER

At this stage an architect or civil engineer should be appointed. A Design Brief about the proposed hospital should be handed over to him/her by management or a hospital consultant. A Design Brief contains overall ideas about the hospital like number of OP, waiting area, investigation rooms, Lab, Procedure rooms, IP rooms, recovery rooms, number of OT, service area etc. Prepare a sequence of activities and thus make a functional planning of spaces. Make a workflow diagram & bubble diagram and hand it over to the architect and discuss thoroughly.

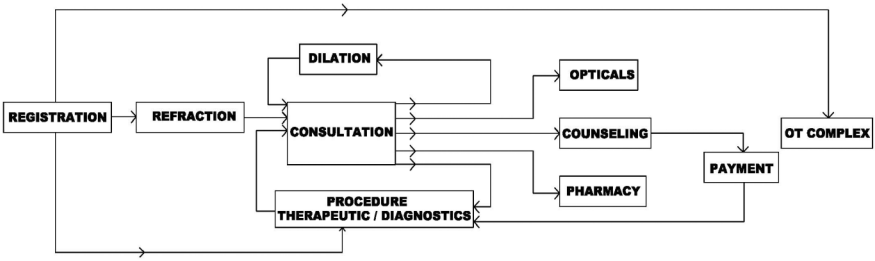
A **flow diagram** shows all the pieces of a workflow and how patient management take place in the hospital. This won't show everything in detail, but is only an overview of the activities that occur in the hospital. Flow diagram will be different for different services in the hospital.

A **bubble diagram** is a freehand diagrammatic drawing made for space planning and organization at the preliminary phase of the design process. Later phases of the design process are based on them.

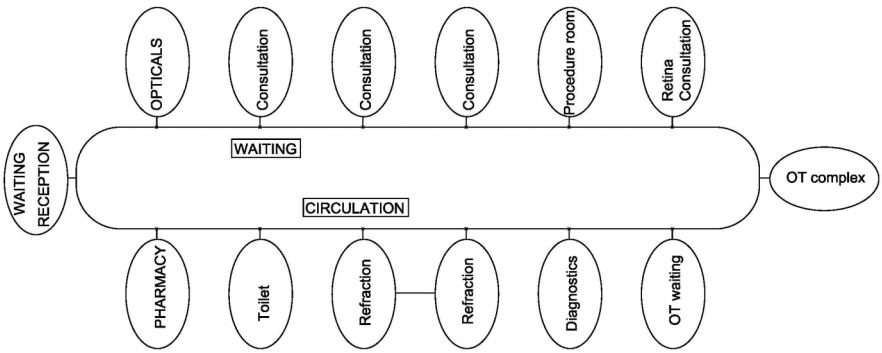
Basically, a bubble diagram conveys information about the spaces of the building, their functions, relationships, and the circulation patterns.

Let the Architect design a basic plan based on this requirement.

Fig1. lay out by architect



FLOW DIAGRAM



BUBBLE DIAGRAM

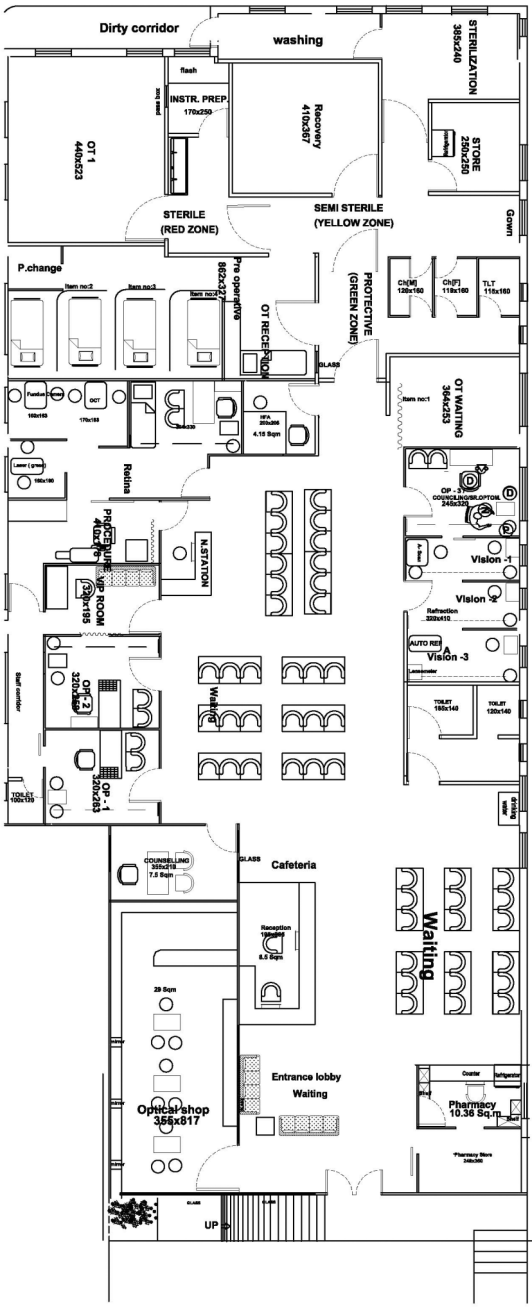


Fig1. lay out by architect

The prevailing Governing Rules, Kerala Panchayath and Municipality Building Rule (KMBR), National Building Code(NBC), Kerala Pollution control board(KPCB) and Fire and safety Department rules are to be followed

Architectural Plans which adhere to building rules are to be submitted to Panchayat/Municipality/corporation/central or district Town Planning for approval. It may take some time to get the approval. During this time detailed drawings or Good for Construction (GFC) drawing can be prepared. This will have details of architectural, structural, Interior design, equipment & furniture layout, electrical & lighting, Fire & safety, plumbing, telephone, data, CCTV, Public address system, Nurse call system, Medical Gas drawings etc considering the clinical and engineering aspect. A GFC drawing shows the micro details needed for the construction without altering the basic plan. This is needed while executing the actual construction.

From the Design point of view, the clinical service delivery area are divided into three

1. Outpatient Department:

[where the patient is mobile while the doctors, paramedics and the equipment are fixed]

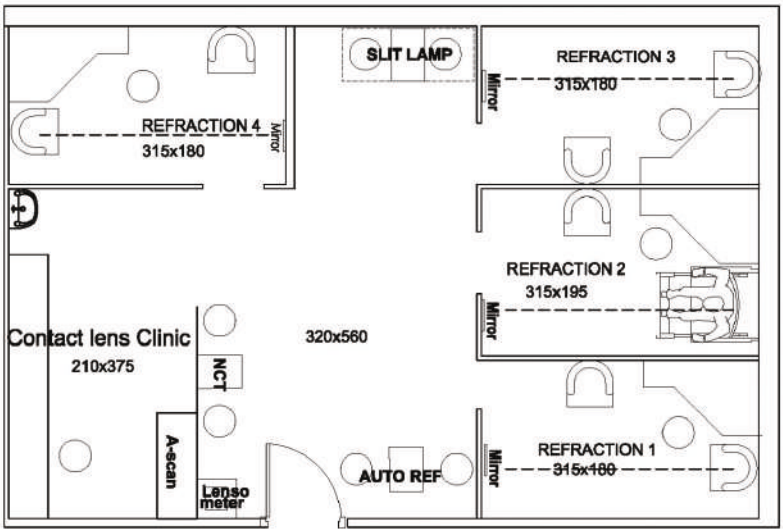
Reception and Waiting area: Reception desk should be positioned in a prominent location at the entrance of the hospital. Segregated counters like Information, OP registration & billing, IP registration & billing, Insurance should be provided for big hospitals. Ample space for waiting chairs, wheel chairs, trollies should be allocated. Patient sitting direction should be arranged in such a way that direct sunlight should not hit dilated eyes of patients. Public toilets, including those for disabled which can accommodate wheelchair, urinals with water saving technology should be adopted. Space for water, coffee/tea vending machine and snack counter should be planned.

Refraction Cubicles: A common room for Auto-refracto-keratometer, Noncontact tonometer, lensometer can be provided for initial assessment. Separate cubicles should be provided for refraction for privacy and to avoid distractions while doing the lens trial. One cubicle should be big enough for wheelchair entry. Following examples show different types of refraction units

Fig2. Refraction with and without chair unit

OP consulting rooms:

300 x 330 cm is ideal for an OP with a chair unit. It will be ideal if the layout is planned so that most of the procedures including refraction and slit lamp examination can be done without shifting patient. Chair unit offers this advantage but can be done even without that. Some retina surgeons prefer one additional examination cot for indirect ophthalmoscopy in addition to



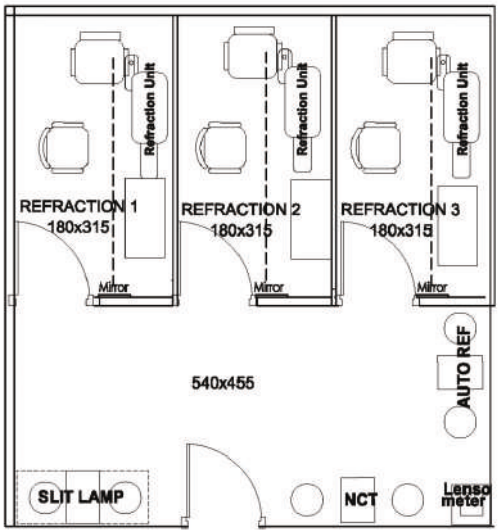


Fig2. Refraction with and without chair unit

chair units. In that case 300 x 390 cm should be provided. Switches of room lights can be positioned wherever the indirect ophthalmoscopy is done so that the surgeon can operate it according to his convenience. Following examples show different type OP designs with chair units and without chair units.

Fig 3. OP

A private corridor at the back internally connecting all consulting rooms, treatment/ procedure rooms and Doctor's lounge/VIP waiting room will be a useful option. A doctor can use two consultation rooms simultaneously. When the doctor is attending a patient in one room, the nurse/optometrist can do the preliminary assessment of the other patient in another op room, and the patient can keep himself ready when the doctor finishes with another patient. The time taken to switch patients between consultation when one is using the same consultation room can be reduced. The total waiting time/area of the patient can be reduced. Consultants can offer second opinion for another patient in a different consulting room without coming to the common waiting area, using this corridor. This corridor can also be used for VIP patient, medical representatives to see the doctor without disturbing the general patient crowd.

Fig 4. OP with staff corridor

Counselling: Can be located near the waiting lobby. A CCTV camera with sound recording is ideal to keep evidence that we have informed them of the possible risks of the procedures being done apart from written consent.

Optical shop: should be provided near the entrance lobby so that it is visible and accessible to outside people also and all patients entering the hospital.

Pharmacy: This should be an air-conditioned area preferably near the entrance. The minimum area of Pharmacy is 10 sqm as necessitated by the drug control department.

2. Wards /Recovery/ Ocular emergency(Casualty):

[where the patient is fixed while the rest of the attendant facilities, doctors and staff are mobile.]

Male and female wards can be separated with common Nurses station and utility rooms like store, clean utility, dirty utility, pantry etc. A/C non A/C facility can also be provided.

3. Operation Theatre/Procedure rooms and Diagnostics:

[Where the equipment is fixed while the patients, paramedics and surgeons are mobile]

Procedure room- I&C, dressing, pad& bandage, subconjunctival/ subtenon injection etc are performed here. A chair unit or procedure table,

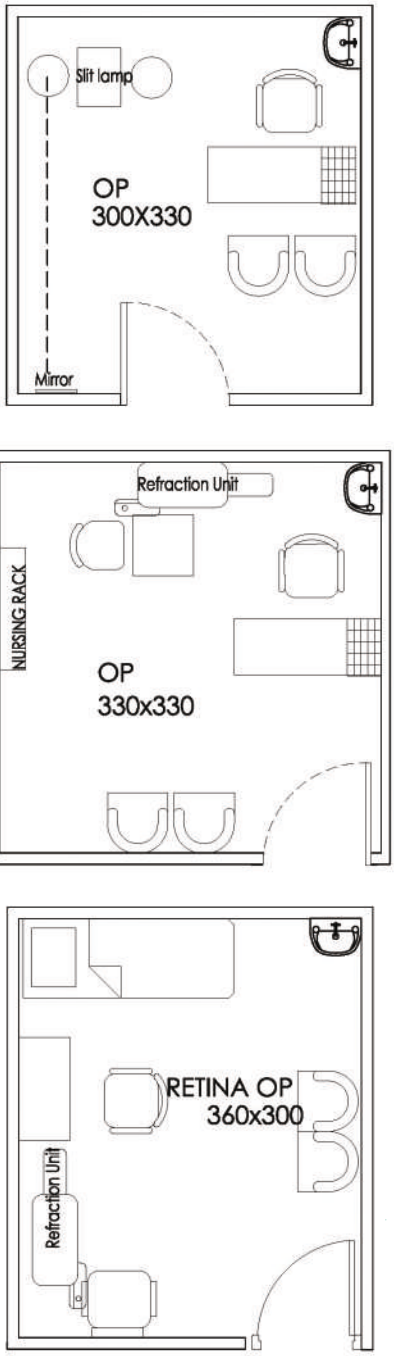

Slit lamp
OP
300X330
Mirror
Refraction Unit
NURSING RACK
OP
330x330
RETINA OP
360x300
Refraction Unit

Fig 3. OP

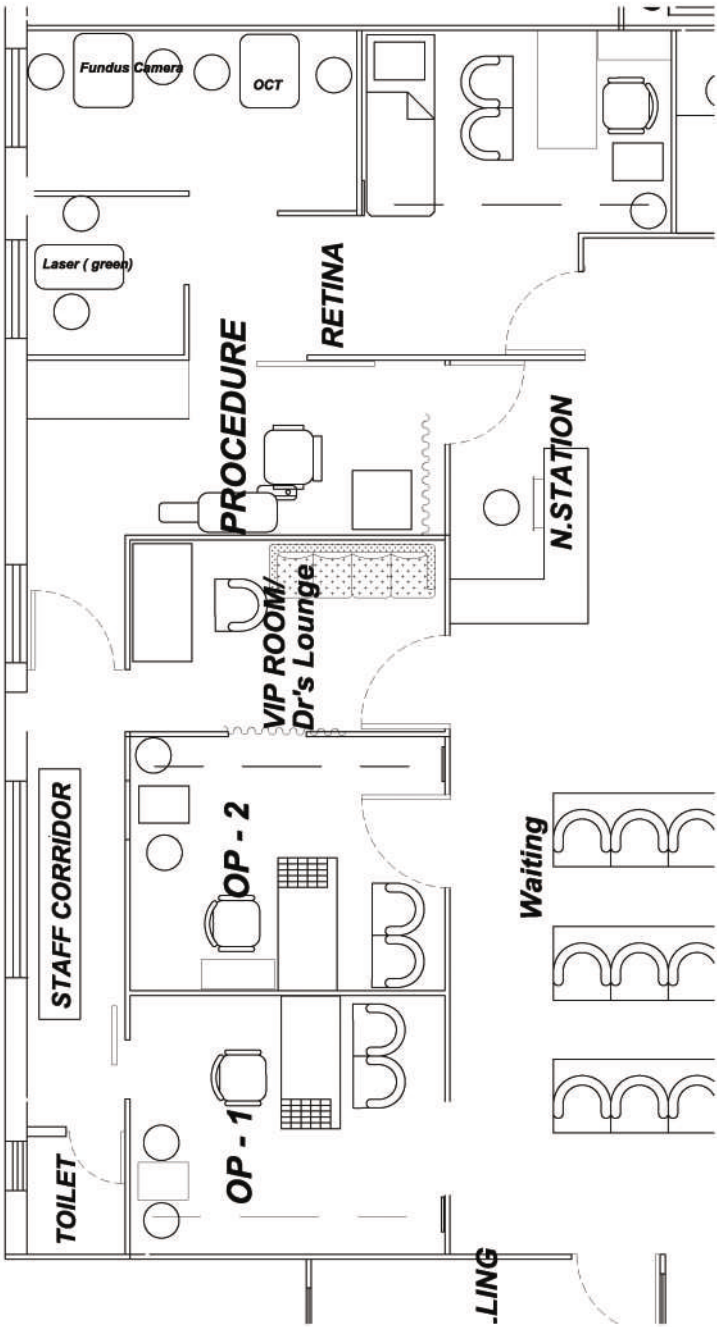


Fig4. OP with staff corridor

cabinets for instrument storage, microscope(preferable), sink with elbow tap should be provided

Diagnostics rooms/ Ocular imaging: equipment like OCT, HFA, Fundus camera, A/B scan etc are kept here. It is better to provide privacy for each of these by giving partitions. HFA should be in a separate enclosure to cut-off all lights and reduce distractions. Air Conditioning with proper humidity control is mandatory here as most of the equipment have optics and sensitive electronic parts. Higher humidity also encourages the growth of fungus in optics.

Operation Theatre

Operation theatre is the area that determines majority of the quality outcome of the hospital. It is one area where there should be zero tolerance on factors leading to compromised surgical result. Much thought has to go into the functional aspect to make it safe.

OT complex is divided into 4 zones of varying levels of cleanliness with the operating room being the most clean and closest to being sterile.

Fig 5. OT and CSSD

Protective zone (Green Zone) - reception, electrical room, pre anaesthetic room, pantry, change rooms, trolley bay, toilets

Clean zone (Yellow Zone) - preoperative room, patient transfer, recovery room, anaesthesia store, staff workroom, instrument packing and sterilisation

Aseptic / Sterile zone (Red Zone)- operating room, sterile instrument store, scrub area, anaesthetist room etc

Disposal zone - dirty wash area, disposal corridor, Janitor's closet etc

Support services

This varies with the size of the hospital. Small and medium eye hospitals may not need all of these. Administration, canteen for patients, bystanders, doctors &staff, dietary kitchen, material / pharmacy store, maintenance, housekeeping, laundry etc should be provided

Plant and utilities in a hospital building

Include electrical panel room/ substation, medical gas plant, ac plant, fuel storage yard, water treatment plant, biogas plant & sewage treatment plant and Fire pump room

Water:- source & treatment, water tanks, conveyance , reverse osmosis treated water, rain water harvesting, sullage & bathroom water, drainage & sewage, treated water reuse, hot water line, chilled water pipe systems for ac

Electrical:- transformer & substation, generation backup, UPS backup etc

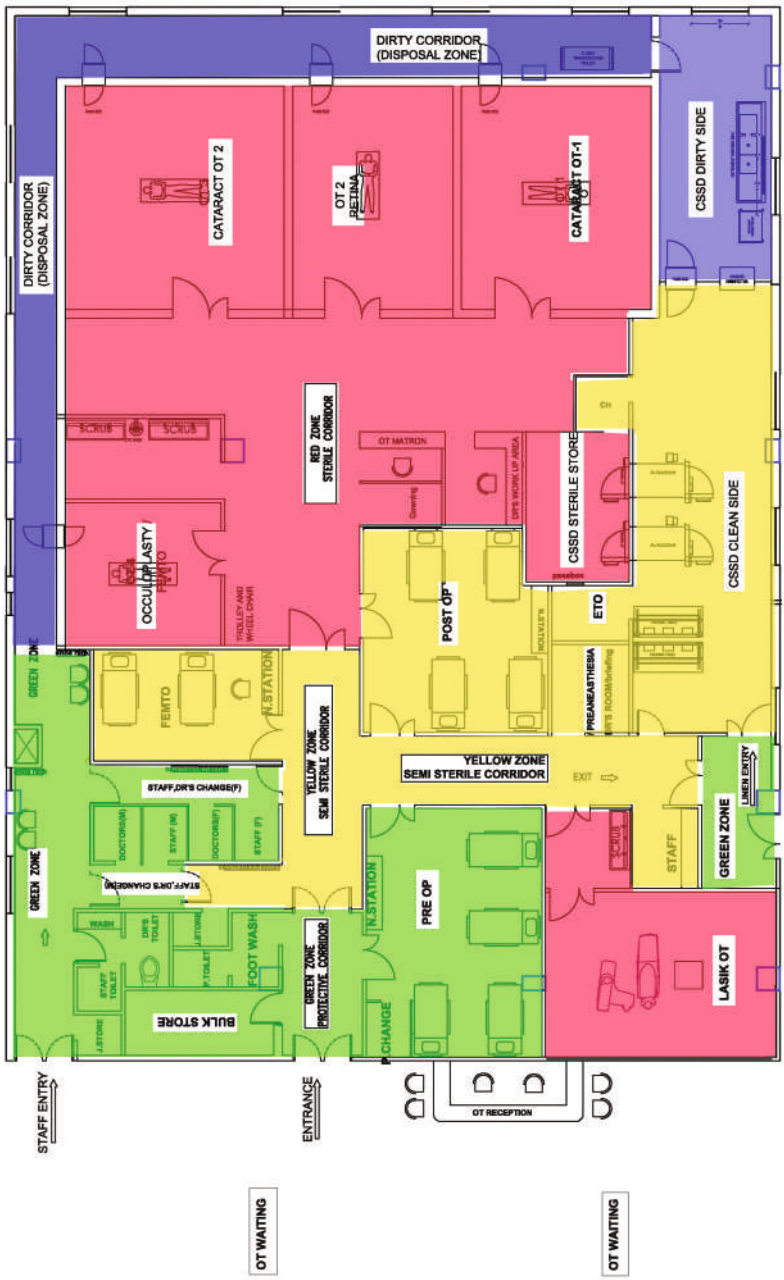


Fig 5. OT and CSSD

ELV (Extra Low Voltage)**:-**surveillance system, smoke detector, public addressing, nurse calling system, television & networking, building automation etc

Medical gas - Oxygen, nitrous oxide, Air 4 bar(medical air), Air 7 bar(surgical air), Vacuum, AGSS (Anaesthesia gas scavenging system) etc

Fire &rescue:-Sprinkler system, hydrant system, fire- water tanks, smoke detectors, heat detectors etc.

HVAC (Heating Ventilation and Air Conditioning) -AC plant, chiller, chilled water/gas lines, air ducts, laminar flow system of OT etc.

Design considerations

Need-led planning must go hand-in-hand with Resource-led planning.

In big/medium eye hospitals certain departments can be placed adjacent or in the same floor considering sharing of equipment, optometrist, counsellor, minor OT etc.

Eg Retina and Glaucoma departments can be placed in one location considering the sharing of equipment like OCT, HFA, Fundus camera etc.

Likewise in big eye hospitals a **cataract Surgery workup area** comprising Counselling, A-scan biometry, ECG, Lab, Physician, Anaesthetist, IP admission/billing, IP pharmacy, insurance office etc can be in one location sharing a common waiting area. This will act as a one-point location for patient who are advised surgery.

Fig 6. cataract surgery workup area

Designing for Flexibility and future expansion

Phase-wise planning should be done initially for short and long term expansion and change within the hospital building and the campus also. The master plan should show phase-wise building plan, parking, circulation like road etc. Modular Pattern of development gives ability to expand to meet future needs.

Allocation and specification of “swing” space to allow temporary relocation of departments during renovation can be planned at the beginning itself. 'Low-tech' departments like wards which are easy to relocate can be temporarily placed in buffer spaces adjacent to “high-tech” spaces like Operation theatre. Later these high-tech departments can be expanded to the 'Low-tech' space by relocating it as and when need arises.

The Planning Grid: Creating a Framework for Design

A planning grid is an architectural design tool. It is an overlay of lines usually represented by a 'long dash-dot' used by architects to create an order when they start to design a building.

A good design of the planning grid helps better utilisation of floor area.

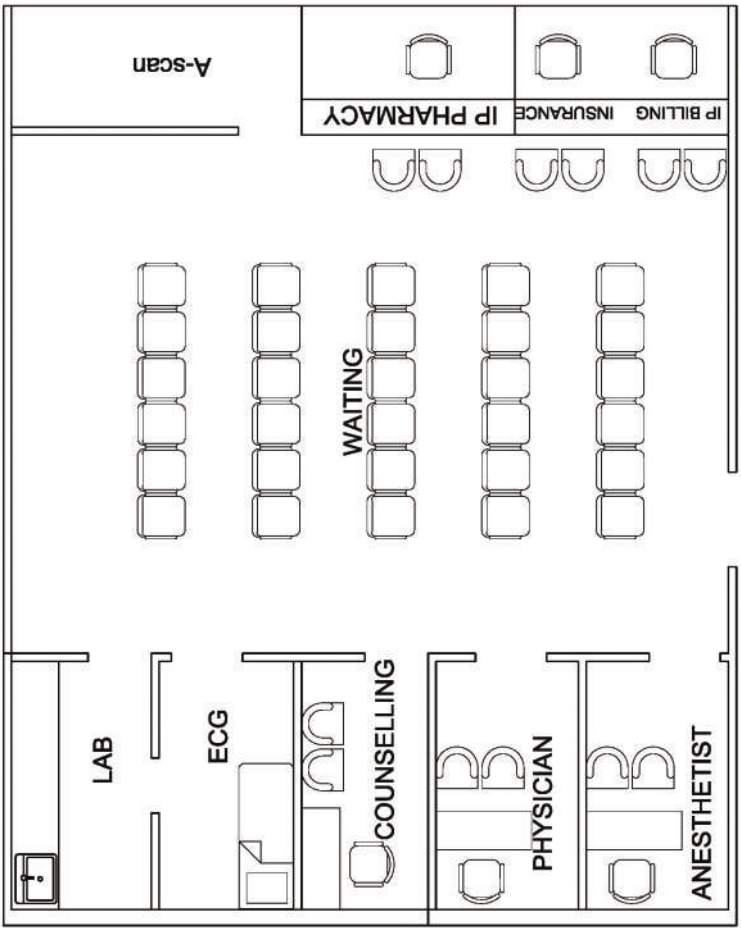


Fig 6. cataract surgery workup area

If the hospital is a vertical building with multiple floors and most floors are inpatient rooms, the planning grid is determined by the layout of the inpatient rooms. The beams and columns are usually aligned to these grids. In the example given below you can see how the planning grid modules of 370 cm x 655 cm are determined by the accommodation desired for a single bed patient room with toilets in most of the floors and OP and Parking in other lower floors.

Fig7. Grid

Circulation - Ease of Way finding

There are horizontal circulation areas like corridors and vertical circulation areas like lift, staircase and ramp. Try circulation with the shortest possible traffic route which helps in better utilisation of space and ease of operation of the hospital. Segregation of dissimilar activities should be planned such as movement of dirty, clean & sterile items. Some areas in the hospital should be quiet and some are bound to be noisy. Careful planning can separate these. Similarly mix up can be avoided between inpatient and outpatient areas, between visitors & staff traffic and between goods supply and exit for waste products. For a better planned hospital, the total circulation area should not exceed 25% of the total built up area.

Corridors: They should have conceptual clarity - designed with purpose. It should enable way finding in combination with signage and graphic symbols. Corridor width of 240 cm is needed for easy movement including turning patient trolleys. The false ceiling should be a removable grid type ceiling so that maintenance of service lines above the ceiling is easy. Operation Theatre corridors should be 300cm wide.

Stairs: Should have absolute level and non-skid surfaces. Risers(height of each step) should be 15cm and treads(breadth of each step) 32cm. Hand rails should be positioned on both sides of stairs and extend beyond the first and last step so that a patient on a walking stick or single crutches can grab the support till the floor. It should have a paediatric hand rail. Ensure fire safety rules. If one side of the stairs is an open area, the height of the handrail should be 120 cm.

The staircase should not directly end to the corridor and use corridor as landing. The landing should be minimum 90 cm extending away from the corridor so that the staircase can be isolated if the corridor is used for the purpose of a sterile corridor.

Ramp: Non-skid surfaces should be provided. The slope should be minimum 1: 12.It means that for every centimetre of rise, you will need 12 centimetre of ramp horizontally. For example, a 10 cm rise would require a 120-centimetre ramp horizontally to achieve a 1:12 ratio

Bed Lifts: Lift door openings should be wide enough to carry bed, stretcher and wheel chairs - 120 cm width for bed entry and 90 cm for wheelchair and patient trolley entry.

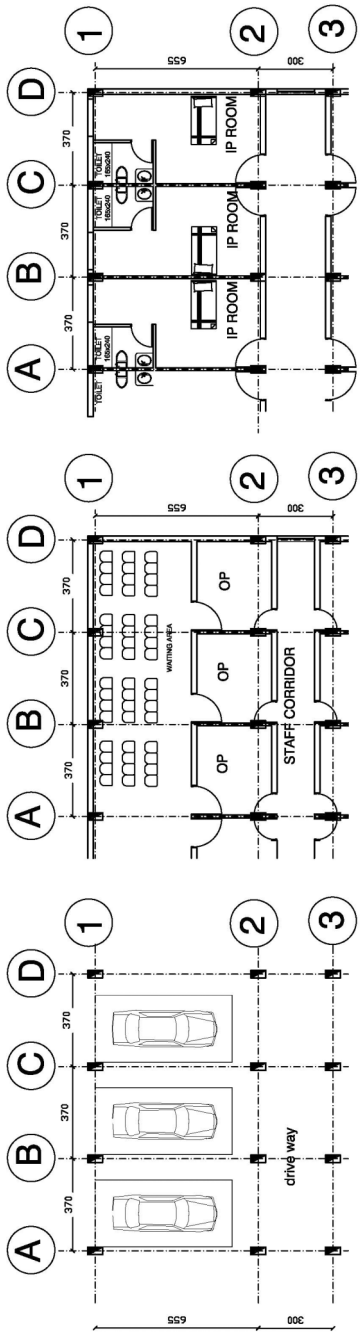

A
B
C
D
1
2
3
370
655
300
drive way
BASEMENT FLOOR - PARKING
OP
OP
OP
STAFF CORRIDOR
WAITING AREA
GROUND FLOOR - OPD
IP ROOM
IP ROOM
IP ROOM
TOILET 180x240
TOILET
FIRST FLOOR - IP

Fig7. Grid

Doors & windows

Doorways need minimum 120 cm clear opening width to allow easy passage to patients/visitors/staff including those on wheelchairs. 150 cm wide is ideal for critical care areas like OT and recovery. Crash guard for doors is essential to protect it from hitting the patient stretcher. All doors in the toilets of the patient area should open to outside.

The rooms/spaces in the hospital should have adequate natural lighting. Each window and/or glazed door should cover an area of not less than 15% of the floor area of the room.

Design coordination and Coordination plan

Considerable inputs from the other agencies like HVAC (Heating Ventilation Air Conditioning), electrical, plumbing, medical gases and inputs from equipment vendors especially in specialty areas like, CSSD and Operation Theatres will be essential to finalize the working plan of the hospital. A coordination drawing should be prepared which shows all services like electrical, plumbing, A/C, medical gas etc in one drawing which ensures that sufficient space is allocated for each engineering service. Like a floor plan, it is equally important to design the space above the false ceiling where all engineering service lines are passing.

The Design Team:

Architect, Hospital Consultant, Structural Consultant, MEP (Mechanical, Electrical, Plumbing) Consultants, Landscape Architect, Interior Design Consultant / Graphic Designer and Biomedical Engineer / Medical Equipment Consultant are the types of consultants required for the successful completion of any healthcare building project

In addition to these consultants, the design team would also include the owner / owner's representative, Hospital Administrator / CEO of Proposed Facility and the Construction Manager.

Conclusion

A patient friendly hospital atmosphere should be created by proper planning by interaction between professionals and even the patient. We cannot replicate one design from a hospital in another location where the requirements may be different. Design the space in such a way which allows patients be partners in their healing. Hospitals have to be built or reengineered with a view that this building is for the next 25 years

Separate all departments at the same time and keep them adjacent. Separate types of traffic at the same time shortening the traffic. During the design process, remember the dictum that "design follows function".

Keep **Patient** as the focus of planning and design.

Concept of Group practice

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Group practice is the need of the hour today. We are already seeing a lot of people coming together for group practice and there has been a lot of interest amongst ophthalmologists to explore this option of practice.

There are some obvious advantages of Group Practice, especially in a field like Ophthalmology. Our setups require a lot of expensive machines, and the technology is changing very fast, which means we have to upgrade/change our medical equipmentquite regularly. A single practitioner finds it very difficult to update his equipment and technology because of the huge costs involved. A group practice makes it possible by getting faster 'Returns on Investment' as there are many more people using the same equipment. Our surgical times are becoming shorter, hence most of the times our Operation Facilities are lying unused. More doctors using the same facility makes a lot of commercial and practical sense. Moreover, group practice also offers the advantage and better service by providing eye surgeons from different specialties under the same roof.

The increasing statutory compliances also make it difficult for a single person small setup to meet all of these. A group practice can do it better as they can afford to hire relevant manpower to take care of all the statutory requirements and thus increase the safety for the patients and the doctors and staff as well.

These are obvious advantages of Group Practice. However, to run a

successful group practice, one needs to have proper synergy between the team of doctors and management. Various members of the team have to complement and support each other. There are two types of models for group practice:

- Multiple Owners (2 or more)
- Single Owner, Multiple Users

I have been lucky to have an experience of both these models. After finishing my training at RP Centre, AIIMS, in 2001 I started my practice in partnership with my colleague. After being together for 15 years, we separated in 2016 and this is when I switched over to Single Owner and Multiple Users model. Each of these models have their own advantages and limitations.

Multiple Owners Model:

This is the model in which the ownership is shared by 2 or more partners. Each partner invests their money and efforts in the organization. The advantages are that the administrative responsibilities are shared between the partners. These partners can complement each other's weaknesses and can bring in their own expertise in management. Some partner may be good in developing the systems, some may be good for HR activities, some for marketing activities etc. The level of commitment in partners is much higher than that in an employee or a visiting consultant.

However, there are some problems that may also creep-in in this model, especially if not planned properly. The decision making may become a bit difficult as there are many players and decision makers involved. Personality issues and Ego and politics may also creep in later, thus complicating the issues.

For this kind of practice to succeed there has to be very good understanding between the partners, well defined systems about dealing with staff and visiting consultants, open and frank channel of frequent communication, etc.

Single Owner, Multiple Users Model:

This organization is owned by a single person or company and the facilities are utilized by many visiting consultants. The disadvantage is that the investment required is huge for an individual and also the amount of administrative efforts required is mostly done by one person. The advantages are that there is a clear chain of command and well-defined responsibilities with no confusion or politics. It is much easier to implement the changes and decisions. A uniform Ethical and Functional atmosphere can be maintained throughout the organization. Since there is no politics involved, and in presence of clear chain of command, it is much easier to work with Visiting Consultants.

In this model, the owner employs a few full-time consultants (if required) on salary and optional incentive basis to take care of regular walk-ins and basic works. The centre is open to other visiting consultants to use for their own patients.

Visiting Consultants:

Visiting consultants come and use the facility to see their own patients and they are paid on basis of work done. There are three types of visiting consultants:

- **Providing Specialty Care**: These consultants run their OPDs at fixed times and also use the investigative, OPD procedures and IPD facilities. Besides seeing their own patients, they also get referral from other doctors in the organization for their own specialty. This helps the consultants as they get more referrals. This also helps the organization to maintain their patients within the system so that the patient need not be referred outside. It also adds to the prestige of the organization to have well known specialists visiting their centre.

- **Using OPD, Investigative and IPD facilities**: These consultants also have regular OPDs and use Investigative, OPD Procedures and IPD facilities. However, these consultants don't generally add on any special expertise and are mostly dealing with their own patients and don't expect any referrals from the organization. These doctors have the benefit of getting to use well managed, fully equipped set up which has all the compliances, statutory licenses, TPA and Panel facilities taken care of.

- **Using Investigation and IPD facilities only**: These consultants have their own OPD practices elsewhere, and they send their patients or come themselves to utilize the investigations, OPD procedures and IPD facilities. These consultants' names do not figure in the website or signboard or letter pad of the organization.

For any association to be fruitful and long lasting, there has to be a win-win for everyone. This kind of synergistic relationship is very critical for long term success. The visiting consultant and the owner both should benefit and both have certain expectations and responsibilities which has to be taken care of.

A visiting consultant has the following benefits:

- No administrative hassles
- Regular updation of technology and equipment
- Get Cross Referrals
- TPAs and Panels, NABH and other Statutory requirements taken care of
- No pressure of Staff, HR, Salary, AMC, CMC, Inventory, etc.

- Take-home package may be better than what they would make from their own setup

A visiting consultant has the following expectations from the organization:

- No 'poaching' of his/her patients: He/she should be assured that the patients coming for him/her would not be diverted away from him/her
- Proper due respect to be given to the visiting doctors by management and staff
- Good and Simple (even if not perfect) accounting system
- Transparency in systems
- Organization's culture of Safety and Ethics should be top notch and should match the expectation of the visiting consultant

This model of Group practice has many advantages for the centre owner. Some of these are:

- More footfalls and Revenues in the centre. More footfalls and more satisfied patients automatically translate into better publicity and a healthy organic growth without spending on unethical, expensive and ineffective advertisements
- Faster ROI on investments and better utilization of machines
- Cross Referrals within the system
- All facilities under the same roof, enhancing the prestige of the organization

To get these advantages, the owner has to make some extra efforts as well. Though most of the system and staff is already in place, one needs to only increase the staff slightly and adapt the systems a bit to accommodate the extra workload.

- The owner has to be accommodative for the bigger picture and should not be 'penny wise, pound foolish' in his/her behaviour
- Accounting may not be perfect, but it must be simple and transparent.
- One has to adopt the systems and accounts for Visiting and Specialist doctors
- A strong EMR system, a strong Appointment and IPD and TPA/Panel desk is very critical to run an organization with multiple doctors
- There has to be a uniform set of rules for everyone in the centre
- The staff must pay equal respect to the visiting consultants
- The owner's name should not be put up very prominently in the premises, as it may threaten the visiting consultants and they may feel that their patients may get 'poached' upon
- Regular interactions amongst the consultants is advisable for better comaraderies and for more cross-referrals

- A very strong and continuous emphasis must be placed on the value systems of the organization so that the patients get the same uniform culture of safety and ethics from every staff and doctor. For example, in our organization, we have enumerated the four key values of **Competence, Integrity, Safety and Compassion**. We have got these values printed all over on our letter heads, posters etc. to act as a constant reminder to every member of the team and also to the patients and attendants.

To conclude, Group Practice is the future in the times to come. Most of us have to start thinking about joining it either as an investor or as a visiting consultant. This ensures reasonable independence for the visiting consultant without the hassles of running an eye centre. Like any relationship, it has to be built on a principle of win-win where both the parties benefit. There is a need of great synergy between the owner, visiting consultants, staff, patients, attendants, etc. for smooth running of a group practice setup. Everyone has to be mindful of the interests of the other partners for the practice to grow. A strong adherence to the value systems is essential for long term growth.

Manpower Planning for a new Eye Hospital

Dr Anup Chirayath
I Vision Eye Hospital, Thrissur

The human resource of any organization would ultimately decide on its success in the long run. This fact applies for an eye hospital also. Skilled, capable and dedicated staff are an asset of any organization. Hence maximum care has to be taken to ensure that time and effort is spent on identifying and selecting a good team.

Manpower Planning is also called as **Human Resource Planning** and basically aims at putting the right number of people, the right kind of people at the right place, at the right time, doing the right things for which they are suited for the achievement of the goals of the organization.

The right number because more staff means more expense besides more staff would mean less work for all. An idle mind is a devil's workshop is an old adage which holds true even for an organization. The right kind indicates that the person to be recruited should be qualified for the job and should have the right attitude which should be in sync with the culture and goals of the organization. Here it should be stressed that a well-qualified and brilliant person may not always be right for an organization.

Manpower planning is not a onetime activity. It is in fact a continuous process and involves many activities. It involves having an inventory of existing man power, forecasting demand and supply, identifying manpower gaps and filling them, employee training and development, employee welfare plans, manpower appraisal etc. An eye hospital will grow with time. As the patients increase more staff will be required. There will be some attrition of staff which

cannot be avoided. Hence planning and recruitment has to be done as an ongoing process.

Categories of staff in an eye hospital

- Consultants
- Administrator/supervisor
- Optometrists
- Nurses-OP,Daycare,OT
- Receptionist
- Pharmacist
- Opticals staff
- Accountant
- Store clerk, Customer care, Marketing
- Maintenance/ IT
- Housekeeping and security

These can be classified as essential staff which would include Ophthalmologists, optometrists, ophthalmic assistants, Pharmacists and optical staff and the rest would be support staff. The essential staff are those who are directly involved in the core business of the organization.

In addition to the above an eye hospital will also need some part-time consultants. These are people who may visit once a week or once a fortnight like a Human Resource consultant who can guide you regarding the statutory requirements like Minimum Wages act, Clinical Establishment act, Provident fund act, Employees state insurance act, Bonus act, gratuity act etc. It is essential that the organization is complaint with all these acts since the government views noncompliance very seriously with hefty penalties.

An auditor is also needed on a part time basis to check the accounts, cash flow, profit and loss, taxation and again statutory compliances like income tax, GST, TDS etc.

An attachment with some placement agency will also be helpful so that vacancies can be filled in a timely manner.

Planning the number of staff needed :

In the Out patient area and OT complex, the calculation of the staff depends on the number of consultant ophthalmologists.

OPD			
consultants	1	2	3
OT			
consultants	1	2	
Scrub nurse	1/2	2/4	
Circulating Nurse	1	2/3	
Preparation room	1	2	
House keepers	1	2	

In the OT also the number of staff depends on the number of operating surgeons and the case load. It will also depend on whether a surgeon is operating with one OT table or two. A fast and skilled surgeon can do more number of surgeries with two OT tables in the same amount of time.

Statutory aspects :

As an Ophthalmologist we need to know certain basic aspects of the government regulations and acts. We need not know the full details for which, as mentioned earlier, one can take the help of an HR consultant.

The government releases the list of the prevalent minimum wages which can be downloaded from the government site or can be had from the Labour department. The salaries of the staff for the various categories have to be based on these directions.

The Provident fund act applies to all organizations employing 20 or more staff. All staff whose wages are less than or equal to Rs 15,000/- per month are eligible to get an employer contribution equal to the employee contribution per month.

The Employees State Insurance Corporation act specifies that any organization with more than 10 employees needs to enroll all those staff with wages less than or equal to Rs 21,000/- per month in the ESI scheme. The employer has to give a contribution equal to the employee's contribution. The enrolled staff can avail free treatment at the designated ESI hospitals for themselves and their families.

The bonus act applies to all organizations with staff of 20 and above. All employees drawing a salary of Rs 21,000/- or below are eligible to get an annual one-time bonus from the second year onwards if the organization is showing a profit. The bonus calculation can be done with formulae easily available from the net or with the help of your HR consultant

The gratuity act requires you to give a lump sum amount to an employee who has worked in the hospital for a minimum of 5 years and is now leaving. The calculation again can be had from the net or better with the help of an HR consultant.

One may wonder why is it necessary to know these, especially the bonus and gratuity, when one is just starting the hospital. The reason is to know about the actual financial liability whenever one recruits a new staff. To illustrate that with an example let's say we recruit a staff with minimum wage of Rs.16,500/-. When one adds the ESI contribution, PF contribution , the bonus and gratuity that may have to be given in case the staff stays with the hospital for more than 5 years, the actual monthly salary may work out to about Rs. 20,000/- per month.

Recruitment :

It is also a process. The first step is to post the vacancies in the organization into the public domain. Even today newspapers are the most effective media to get the message across. One can also post in the various social media targeting the eligible groups. Friends already running eye hospitals can also be of great help.

The second step is to go through all the applications in detail. The scrutiny can be done by the persons skilled in that area. For example an accountant's application should be scrutinized by an auditor. Once the suitable applications are selected then the candidates can be called for an in-person interview.

It is better if the interviews are conducted by at least two people of the top management. Conducting a good interview is a skill learnt with experience. The actual assessment of the candidate happens during the interview. The CV of the candidate will tell you about the academic qualifications, the excellence or lack of it, whether the person has come from a reputed institute and the work experience. It will however not tell you about the attitude of the person, whether the person is a good team player, whether he or she will stay long in the organization. Many of these finer aspects can be picked up in an interview by an astute interviewer. It is always desirable to have a list of points that you should be asking the candidate lest you forget something. Besides asking the candidate about their details it is equally important that we tell them about our organization, our work culture, importance of punctuality, attendance and the work that is expected from the person. For small clinics it is desirable to have staff that can multitask. The candidates should be informed very clearly about our expectation during the time of the interview itself. For instance an optometrist may need to double as an optical sales person or may have to help out with patient counseling. Similarly an Ophthalmic assistant may need to

have to manage the OP during OP hours and later assist for surgeries in the OT, a maintenance staff may need to work as an errand boy and as a driver. If these expectations are not informed in the beginning itself the candidate is likely to resist later on. A small clinic can save on a lot of staff by this sort of multitasking.

Before any new recruitment it is important to first assess whether there is an actual need. Recruitment decisions should be made after proper planning and assessment. Besides multitasking another strategy that can be used to cut down on staff is offering overtime. Many staff may not mind working a couple of hours more if they are compensated adequately. During off peak hours skeletal staff would be adequate to manage the OP. The aim should be to give good service to the patients with minimum staff. At the same time, one should plan for sudden staff shortage due to unannounced leave or sudden resignations. Marriages, pregnancies etc are amongst the commonest causes for staff taking long leave or leaving the organization. Though on paper it is expected that the staff leaving should give at least one month prior notice, all may not follow that.

Recruiting doctors:

A lot of thought and planning should go before recruiting doctors since they are the backbone of the hospital. It is better to enquire about the doctor beforehand even before calling them for an interview. Many important points like the surgical experience and skills, clinical skills, patient communication skills etc should be enquired from the hospitals where the doctor has worked before or from friends and colleagues who have worked with the doctor. This applies especially for senior consultants. The interview should mainly focus on points like working hours, timings, compensation etc. The doctors should also be told very clearly about the facilities available in the hospital like equipments in the OP and OT.

Recruiting Optometrists:

The next most crucial position in an eye hospital is obviously an optometrist. Nowadays the new generation ophthalmologists may not be very proficient in retinoscopy and refraction. Since a significant part of the revenue of an eye hospital comes from the optical shop, recruiting a good optometrist makes sense. All other investigations like biometry, field testing, pachymetry, topography, OCT etc are all done by optometrists nowadays. Even contact lens fitting falls in their domain. A good optometrist is a big asset. Even a small clinic needs at least one good senior optometrist. The institute from where the candidate has done her course is important. Some institutes train their students very well while some are just businesses to make money. Only those applications from good institutes should be even considered. During the interview it is also important to make the candidate do an actual refraction. We

see to it that our senior optometrist assesses the technical skills of the candidate— whether a proper history is being taken, whether the previous glasses are being checked, whether the occupation and hobbies are being asked along with the actual objective and subjective refraction.

Other points:

During recruitment along the technical assessment certain other important aspects should also be assessed. It is important to select the person right for your institute who may not necessarily be the best person. For example if a candidate with excellent credentials is chosen and the person leaves after 6 months then all your efforts have been wasted. Hence it is important to choose a person who is good and who is likely to stay with you at least for a few years. It is better to enquire about how far is the candidates' house from the hospital, whether she has to change two or more buses to get to the hospital, whether she has her own vehicle, whether she is willing to stay in a hostel. All these points will help you assess the longevity of the candidate with your organization. All would vociferously claim that they are in for the long haul but that would be just to get a job. Once they experience the practical difficulties in commuting their motivation will gradually come down and they will start looking for options nearer home.

Lady candidates may have their own problems like reluctance to travel after dark, need to reach home early due to small children at home which would restrict their options of working late. These points should be considered so that they are recruited accordingly. If their concerns are addressed they are likely to stay long with the organization. Ultimately one should assess the need of the candidate for the job. If the socioeconomic status of the candidate is such that the person is badly in need of the job then such a person if recruited is not likely to leave the organization.

After selecting the candidate it is important to put them under probation before making them permanent. A probation period between 3-6 months would be ideal. It gives one the opportunity to actually assess the candidate on the job. Some candidates may shine during the interview but may fail miserably on the job. After the probation period one can decide whether the candidate is suited for the organization. No statutory obligations exist on discontinuing the services of a candidate on probation.

All these are just some practical tips which may help in choosing the right person. It is time and effort well spent. A good employee is a great asset to the organization whereas a wrong person is not only useless but can do a lot of harm. Having a good team makes the journey more comfortable and exciting.

Medical equipment purchase planning

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Planning is important in everything and is more important when we go for a long-term plan of starting an eye hospital for your life time or for a group practice. The usual question is from where you will start. You must have used some instruments while doing postgraduate course or when you worked in some hospital. Definitely that will help you. But that alone is not enough for you to plan for an investment of a life time.

Advice

Get opinion from a group of experienced people in this field. Your teachers, good friends working in some institutions and involved in purchase of instruments can help. But do not think everyone is fair enough in advising you. So verify each advise with someone else. You should at least visit 3 eye hospitals with prior intimation and permission and spend enough time in assessing and to find out service conditions etc. Of course, you have to attend a few trade fairs associated with state or national conferences. There you can see, compare and get opinions from your senior experts.

Which all instruments to buy?

Initially you have to plan your magnitude of practice, both starting and expansion in the near future. This is based on the number of doctors and the sub specialties you start. In group practice definitely a number of doctors, optometrists and other supportive staff usually present at a time.

Make a list of instruments required.

We can divide the instruments to high quality and average quality instruments. But never plan for any poor quality instruments. Some

instruments are very crucial and for that type of instruments you have to go for high quality even if it is imported and costly, because these are very important for your ease and accuracy and in turn your reputation and for the growth of the hospital. You can consider about second-hand good machines. But you have to be very careful about the service condition of these ones. Some of the instruments can be considered to reduce the cost of initial investment. In some areas instruments are available on lease. Now many companies are giving instruments on multiple installment conditions. This can be tried and before that discuss with previous users. For all finances, regular bank loan should be the first choice. Some companies arrange loans from some financial institutions. Never jump into it without considering all aspects.

Bundling

In the present scenario bundling of instruments with other consumables is a good option. But definitely discuss with other close seniors and experienced people. Many people won't disclose the actual terms. Have a good bargain with at least two companies and do not jump into decisions. The company people also will tell you that do not disclose to others because you are given a deal which is not given to any other institute.

High quality instruments.

Make a list of high-quality instruments in your situation. This list may be different in another group. Following are the usual high-quality instruments considered.

- Auto refractometer.
- NCT/ Applanation tonometer.
- Operating Microscope.
- Phaco machine.
- A scan/optical biometry
- UPS
- EMR.

The refraction still remains the bread. Even if you are a good phaco specialist, if the glass prescription goes wrong, no one will come for cataract surgery. So you need very accurate auto refractometer and good optometrist. This is same for your applanation and non-contact tonometers. The most important instrument in any eye hospital will be a very good operating microscope. So you cannot compromise on it. Many good brands are available. Good brands even though costly, will last longer. Your surgery will be comfortable and you will live longer. To start with, base model will be OK. Then the key instrument is a good phaco machine from a company having good service reputation. If it is going out of order your hospital balance will be in real

trouble. Good A- scan or optical biometer will decide on the number of satisfied patients. Start the hospital only with EMR of good quality and service. In future you cannot work without EMR. The Government also will make it mandatory. A good EMR with efficient search option will make management easy and patient movement in the hospital fast.

Average quality instruments.

These we can go for the sake of financial problems in the starting of hospital.

Indian Slit lamps.

Desktop computers.

Optical fitting machines.

Ophthalmic chair?

Indirect ophthalmoscope.

YAG Laser.

B scan etc

At least one Slit lamp can be a good imported one. Rest can be good Indian slit lamps. May be later you can switch to better one with photographic facility. The good thing is that the quality of Indian slit lamps have increased compared to earlier days. In case of EMR you can purchase average configuration personnel computers. You don't need very high-end computers to run your EMR. Regarding ophthalmic chair units, it makes a better impression on patients. You should purchase enough number of 20D, 90D, Gonio lens etc. Indirect ophthalmoscopes initially can be shared in two OPDs. Definitely retina OPD requires separate one.

In case of YAG laser Indian ones are of reasonably good standards and you will get better services. This is same in case of B scan also. Other OT instruments like ECG monitors and defibrillators, you should not compromise. Another vital instrument required in operation theatre is a dehumidifier which reduces your infection rate and also increase the life span of vital instruments like operating microscope.

One should not compromise on autoclave. Go for only horizontal autoclave for ophthalmic OT. You can get reliable flash autoclave for emergency purpose. ETO sterilizer, either you can purchase or can get it done in association with nearby hospital.

Specialty OPDs

For Glaucoma or even for general ophthalmic practice a good auto perimeter is required. Which one to buy depends on your finances. Indian companies are good. But try to get world standard one, because patient will come from other hospitals with that type of field results. OCT, also is useful and if you have a retina clinic definitely it is a must.

Retina instruments.

OCT of latest and base model which can be updated is the best choice. If you are having a retinal specialist,you should have retinal lasers of good quality. Again, India makes are of reliable standard. Now-a-days the number of lasers is coming down with increase of intravitreal injections. So most of the time retinal lasers may not be financially viable. Good fundus camera with fluorescein angiography is a must in retina clinic. Later you can think about higher end machines.

Cornea clinic

Good topography machines and specular microscope are required. Specular can be used for your cataract preoperative assessment. Good quality crosslinking machines are very viable if you have enough cornea cases.

LASIK.

The usual question is whether to purchase in the starting of eye hospital or not. It is better to delay unless you have enough doctors to refer the cases to your hospital.

AMC or CMC

In the present scenario you have to be very careful about AMC and CMC conditions at the beginning of purchase itself. Otherwise even a low bargain can turn out to be a burden later. In the initial purchase agreement itself try to get 2-3 years of warranty by bargain. Discuss with supplier about the AMC/CMC amount before finalizing purchase, otherwise they will increase the rate to very high amounts. Make sure that they have service centre nearby or later you will be in trouble.

In conclusion purchasing instruments require lot of Plan, Study, Discussion, visiting other hospitals, good bargain with companies and systematic protocol for maintaining instruments.

Electronic Medical Records

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The digital age has driven the healthcare providers to organize patient information into databases for storing accurate clinical information of patients.[1] These databases are known by the terms electronic medical records (EMRs), electronic health record (EHRs) or personal health records (PHRs). An EMR contains the results of clinical and administrative encounters between a provider (physician, nurse, and others) and a patient that occur during episodes of patient care. To supplement the provider-generated information in the EMR, there is the personal health record (PHR), a medical record maintained by the patient. The PHR includes electronic copies of information patients have received from their providers. Finally, the concept of the EHR was formulated to integrate an individual's multiple, physician-generated, electronic medical records and the patient-generated personal health record. Intended to be comprehensive, the EHR should facilitate optimal management of the health of an individual or, when used in aggregate, of a population. EHRs should allow sharing of information about patients between any authorized providers.[2]

The role of EMR in an Ophthalmology Practice

Ophthalmology, the specialty, involves both medical and surgical care, with a heavy reliance on clinical imaging and documentation involving numerical, text-based and image-based elements.[3] Thus, Ophthalmology is well suited to the use of EMR.

The Ideal EMR

An ideal EMR should be user-friendly and secure. It should desirably have the following features:

Data security

Access to confidential patient data is of prime importance in an EMR. The current systems employ sign in options with different levels of user privileges. However, these password driven access controls are vulnerable and could put the security of the data at risk. Incorporation of newer authentication methods like biometric user identification will make the data in an EMR more secure.

User-Friendliness

The doctor-patient interaction is a very essential part of the care delivery process. If the doctor has to spend a major proportion of that time on data entry and mouse clicks, then it takes away the vital component of face-to-face patient care. This may be perceived as a lack of compassion by the patients. Current EMRs may need 6 to 18 mouse clicks for a simple prescription to be generated. If the doctor has to type in most of the data in addition to these mouse clicks, it not only adds more burden to the healthcare personnel, but also result in even lesser time in communicating with the patient.

An ideal EMR should limit the number of keyboard strokes and mouse clicks. This could be achieved by using various macros (a macro is an action or a set of actions that one can run as many times as one wants. The macro contains all the mouse clicks and keystrokes for a particular action) for entering standard clinical parameters, say for example, a normal postoperative evaluation finding in an uneventful cataract surgery. All these findings could be entered into the EMR with a single mouse click, if pre-programmed macros are available.

EMR window (Fig 1) showing different macros (in this window, the normal post op findings are populated in the findings section of both eyes on clicking the 'postop' macro button, and then selecting 'both eyes'.

Data Storage

As the EMR database grows over the years, with the large datasets of images of each patient, the need for digital storage increases. The large sized hard disks are local storage solutions. Most EMRs run from a parent server connected to different nodes or user terminals, wherein the data is stored from all nodes on the server. The server may have a mirrored hard disk which mirrors the data written on to the main hard disc. This makes the local data storage safe and protects data loss in an event of hard disc failure. An external backup is always done and this has to be an off-site storage to prevent any data loss in the occurrence of a major server failure or a catastrophic event destroying the IT infrastructure at the facility

The data backup window in an EMR (Fig 2)

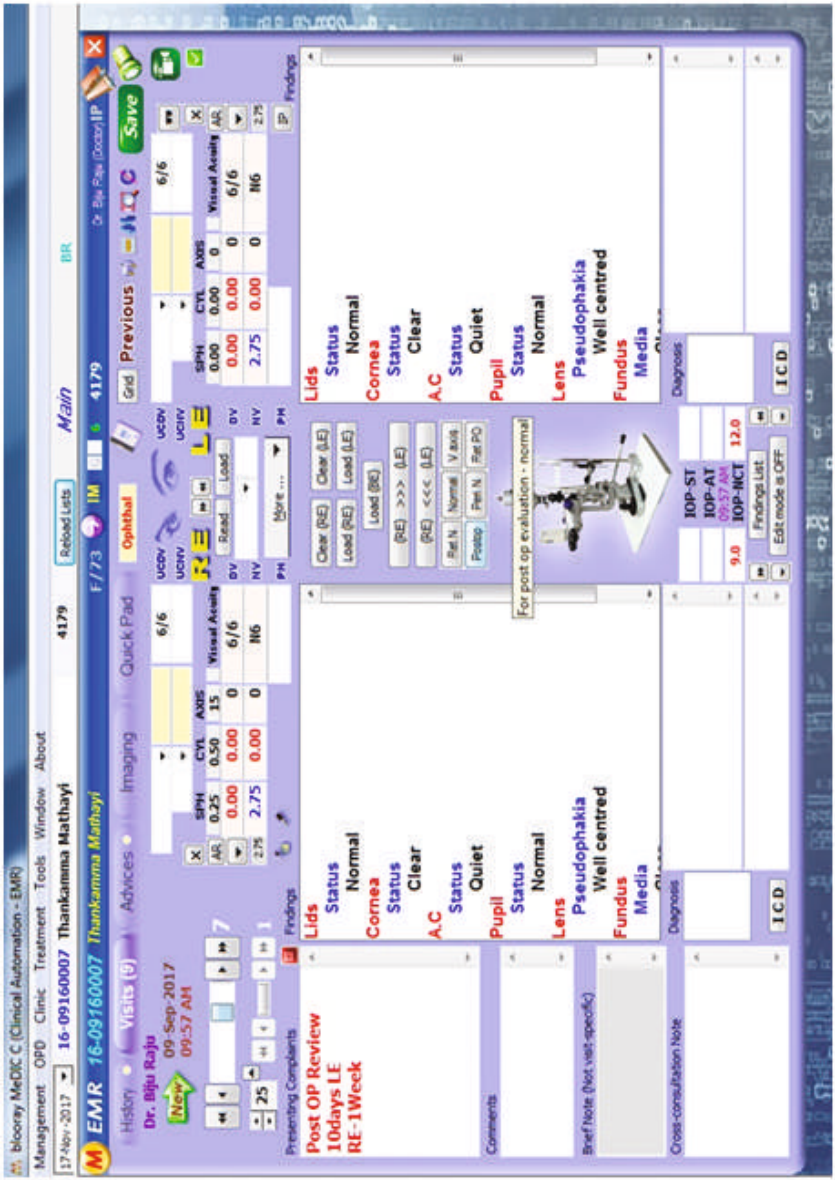
bloorayMeDIC C (Clinical Automation - EMR)
Management OPD Clinic Treatment Tools Window About
17-Nov-2017 16-09160007 Thankamma Mathayi 4179 Reload Lists Main BR
EMR 16-09160007 Thankamma Mathayi F/73 IM 6 4179 Dr Biju Raju (Doctor) IP
History Visits (1) Advices Imaging Quick Pad Ophthal Grid Previous Save
Dr. Biju Raju
New 09-Sep-2017 09:57 AM
Presenting Complaints
Post OP Review
10days LE
RE-1Week
Findings
Lids
Status Normal
Cornea
Status Clear
A.C
Status Quiet
Pupil
Status Normal
Lens
Pseudophakia
Well centred
Fundus
Media
Comments
Brief Note (Not visit-specific)
Cross-consultation Note
Diagnosis
ICD
Clear (RE) Clear (LE)
Load (RE) Load (LE)
Load (BE)
(RE) >>> (LE)
(RE) <<< (LE)
Ret N Normal Y Axis
Postop Pet N Pet PO
For post op evaluation - normal
IOP-ST
IOP-AT 09:57 AM
IOP-NCT 9.0 12.0
Findings List
Edit mode is OFF
SPH CYL AXIS Visual Acuity
AR 0.25 0.50 15 6/6
DV 0.00 0.00 0 6/6
NV 2.75 0.00 0 N6
PH More ...
SPH CYL AXIS Visual Acuity
DV 0.00 0.00 0 6/6
NV 2.75 0.00 0 N6

Fig 1

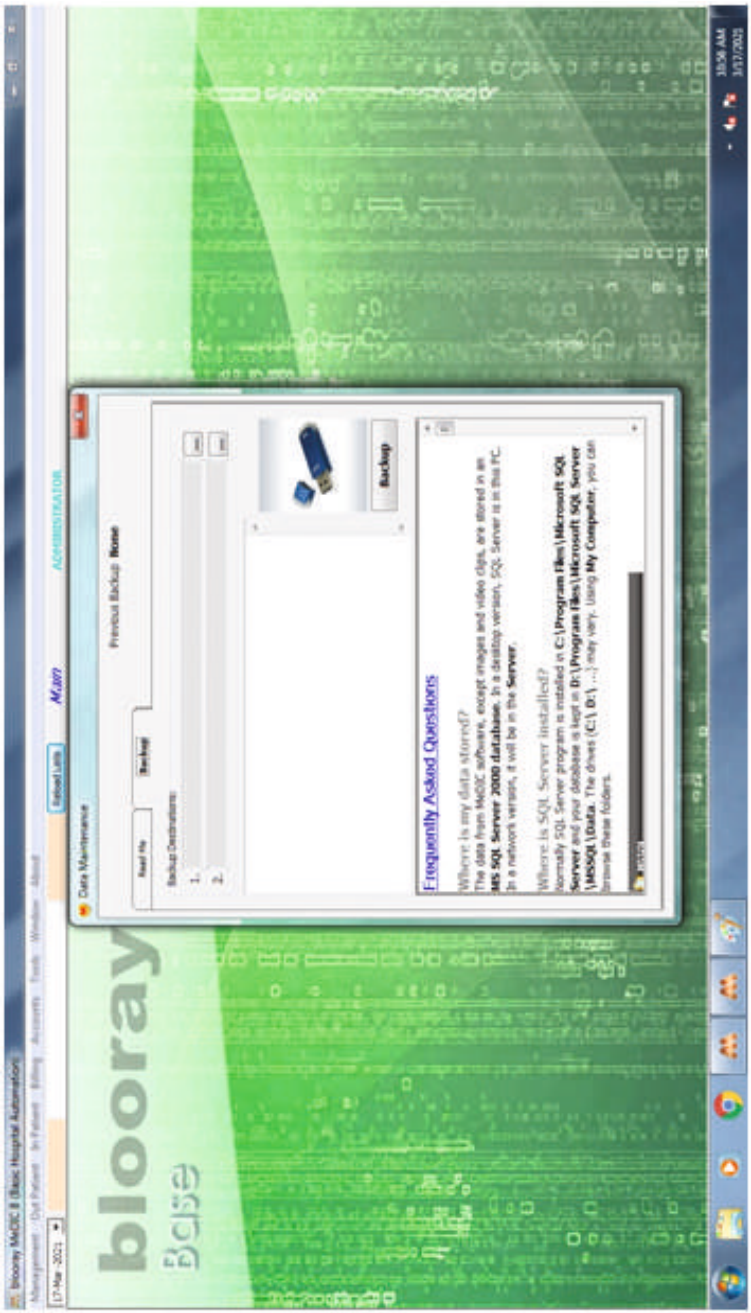
bloorayBase
Data Maintenance
Backup
Frequently Asked Questions

Fig 2

The ideal solution will be the addition of a cloud based EMR with cloud-based storage of the data.

Transparency

The accounting system in an EMR should be robust. In a group practice, where multiple surgeons are working together, the financial management system should be integrated with the EMR for financial transparency. In addition, there should be clarity and accessibility to required patient records during cross consultation. This helps in maintaining harmony in group practice.

All records in one EMR - a paperless hospital

This includes clinical findings, surgical notes, preop evaluation details (e.g LASIK preop evaluation notes), Laser details for retinal lasers, images, scans, diagrams etc.

Easy access to details

The search facility should be fast and intuitive in an EMR to save time and effort of a healthcare professional. A chronological report of all visits will help physicians to monitor the status and clinical improvement of patients in a short time.

Chronological report of all visits of a patient in an EMR (Fig. 3)

Data analysis

Incorporation of Artificial Intelligence (AI) will help analyse the big datasets that are generated from the EMR. With a click of a button, huge data can be analyzed. Multicentric data analysis also becomes easy if there is a common cloud-based storage. In the feature, AI may be able to suggest the most appropriate and individualistic therapeutic option derived from a huge data set of similar patients.

Advantages of EMR

- Simultaneous Sharing of medical records by various departments
- Space saving benefit of a digital records environment
- e-prescriptions are sent to pharmacy and to optical outlet
- Warning signs of potential drug-drug interactions and their allergies
- Maintains real-time history of patient's medication record avoiding omissions and duplications
- Better organized than paper records allowing searching and querying
- Eliminate illegible handwriting
- Draw on pre-set diagrams
- Integration of images & videos from OCT, fundus camera, HFA etc.
- Take instant snap-shots from slit lamp camera
- Accurate and efficient patient billing

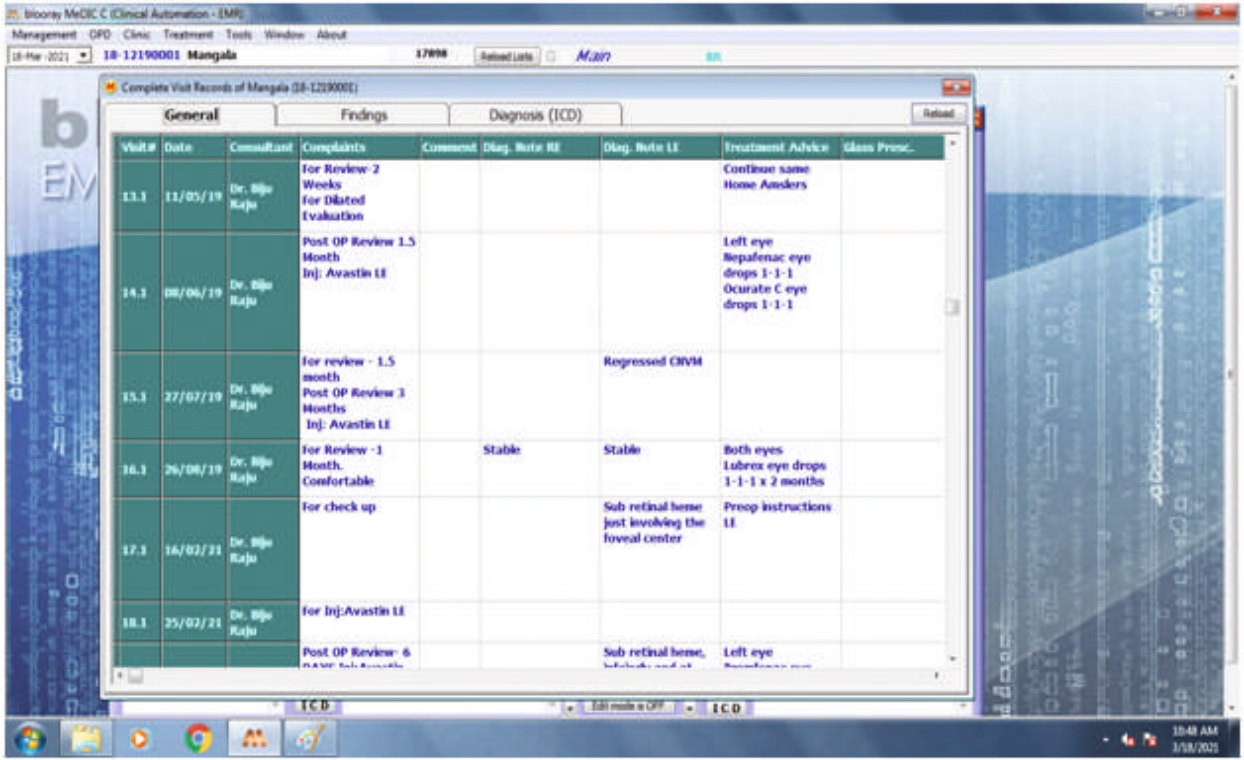
Management OPD Clinic Treatment Tools Window About
18-12190001 Mangala
Complete Visit Records of Mangala (18-12190001)
General
Findings
Diagnosis (ICD)
Reload
Visit# Date Consultant Complaints Comment Diag. Note RE Diag. Note LE Treatment Advice Glass Presc.
13.1 11/05/19 Dr. Biju Raju For Review-2 Weeks For Dilated Evaluation Continue same Home Anders
14.1 08/06/19 Dr. Biju Raju Post OP Review 1.5 Month Inj: Avastin LE Left eye Nepafenac eye drops 1-1-1 Ocurate C eye drops 1-1-1
15.1 27/07/19 Dr. Biju Raju For review - 1.5 month Post OP Review 3 Months Inj: Avastin LE Regressed CNVM
16.1 26/08/19 Dr. Biju Raju For Review -1 Month. Comfortable Stable Stable Both eyes Lubrex eye drops 1-1-1 x 2 months
17.1 16/02/21 Dr. Biju Raju For check up Sub retinal heme just involving the foveal center Preop instructions LE
18.1 25/02/21 Dr. Biju Raju For Inj:Avastin LE
Post OP Review- 6 Sub retinal heme, Left eye
ICD
ICD

Fig 3

- Security of medical data
- Print summaries in a single click
- Interaction between consultants
- Eliminate Medical Records Department
- Ultimately increase the no. of patients served per day
- Improve overall efficiency of patient care

EMR - the challenges

- Initial cost
- Selecting a suitable EMR software from a reputed provider
- Lack of any cook-book approach to start EMR
- Need to decrease patient flow during the migration period
- Potential downtime due to unexpected bugs and technical issues
- Major concern: Distraction from patient-interaction
- Reluctance of doctors to embrace and implement EMR in practice
- Staff training
- Incorporation of previous paper records
- Maintenance of network hardware
- Ability to keep backup system
- Ensuring continuous support from the EMR provider
- The legal issues of consent, surgical record keeping etc

Conclusion

EMRs in Ophthalmology is a big step forward in the digitalization of patient data. It helps in integrating all the different datasets in an organized and easily accessible digital format. The benefits for EMR far outweighs the challenges. With improvement in technology, AI, cloud storage, data security and with user-friendly EMRs, more Ophthalmologists and Institutions are moving forward the digital way.

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ETHICAL HEALTHCARE MARKETING

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"Medicine is a profession whereas healthcare is a business". The whole lot of confusion in healthcare marketing comes from not understanding this. Today in the changing scenario in healthcare some form of marketing is essential.Lot of time and money is invested so that it should reach the target population in the shortest possible time. This situation makes marketing all the more essential. If the return on investment does not happen the whole system will collapse. So all those who blindly criticize marketing should understand this aspect. In healthcare, profession and marketing should go hand in hand. If you have invested your time and money you should get something back. Certainly, unethical practices have to be curbed at any cost

Why Fear Marketing?

The whole lot of medical activity may turn to overtly commercial one. In the past and even now advertisement is considered below the dignity of the profession even though things are changing. Some advertisements may play on patient fear and vanity to exploit. Few people will minimize the risks and exaggerate the effectiveness to rope in more people. That is why marketing is a taboo for many. This can be overcome with best practices in place.

Marketing & Advertisement

Lot of people confuse marketing with advertisement. They are "cousins" not "twins".Marketing is a systematic plan of business activities that collectively works to attract and retain individuals who are in need of your service where as advertisement is just one of many communication tools typically a persuasive message that targets specific audience.

Healthcare Marketing

It is a relatively nascent field. Necessary regulations and best practices are yet to come. It certainly helps the patient to know the available services and options in that area. Researchers and regulators need to provide guidance and criticism of how a medical practitioner should conduct marketing. Health care marketing requires a delicate approach to meet moral and ethical standards. It should be able to educate patients and build trust. We must always maintain patient anonymity. Claims and promises must be real. Every institution should develop policies for marketing. Examine and identify unintended adverse effects. Never denigrate the work of colleagues. As issues in healthcare marketing have always been controversial and complex, ensure it does no harm.

Objects of Health care marketing

1. Patient acquisition
2. Patient retention
3. Patient win back
4. Attract New movers

Myths of healthcare marketing

- We have enough patients so we don't need marketing
- We are getting enough referrals so we don't need marketing
- It is too expensive to advertise
- I don't click on advertisements so people are unlikely to use it
- My website should be only about health education
- I purchased a new equipment so I have to advertise
- We already market using social media
- Marketing is not working if I am not getting calls

Six pillars of healthcare marketing

1. Professional referral marketing
2. Internet marketing
3. Branding
4. Internal marketing
5. External marketing
6. Public relations

1- Professional Referral Marketing

It is all about building relationships. Don't do what your referring

doctor hate. They should not have an impression that you are stealing their patient. You should always keep the primary physician informed about the patient's condition. You should see the referred patient promptly. Don't tell that the primary care diagnosis was wrong and do not talk down of them. You should not refer the patient to another without consulting the primary care physician. You should be available when treatment is unsuccessful. You should not refuse to take lesser paying case after taking too many good paying cases.

2-Internet marketing

You must have a good website with search-engine optimization. You must use all social media platforms such as FaceBook, Whatsapp, Instagram, Google, TV, Radio etc. Fear of ethics stands in the way of giving patients the care and information they need by internet marketing

3-Internal marketing

It is a very effective and simple tool to educate the patients and relatives who come to the hospital regarding the facilities and services available

4-External marketing

Tools used are Advertising Bill boards, Camps, Talks, Presence in the news, Podcasts, You Tube channel and BIG NO to paid advertisements

5-Public relations

Out reach camps

Social media

Healthcare activities and education and recently covid vaccination services

Charitable works

6-Branding

Is a process of communicating a unique selling proposition or differential that set a product apart from the competitor. A logo and slogan always helps

Unethical acts - Medical Council guidelines

All acts of professionals are governed by medical council but institutions are not monitored

RESPONSIBLE MARKETING

Marketing which is trustworthy, informative and honest with co-regulation and self-regulation is called responsible marketing

Paths to responsible marketing

We will have to appoint a marketing director

Understand the regulatory laws

Must have an internal review process

Messages must be accurate and not misleading

Information includes risks and other relevant data

Advertising Partners

Always keep them informed as they are unaware of the ethics involved. They don't know this product is different as they may be working with the same strategies as for other products. They are not intentionally deceiving. It is our duty to correct them

Good marketing practices

Follow all guidelines set forth by council

Avoid superlatives like the best, most effective or anything you want to prove and do not use wordings that promises results that you cannot certainly deliver.

Don't disparage other providers or claim that others in the field are inferior. Don't employ actions to provide patients testimonials. Stay away from fear-mongering and say no to paid advertisements. Prove your value through your own skills.

As the demand for cosmetic and refractive surgeries are on the rise in Ophthalmology, they are placed in the forefront of marketing. At the end of the day they are profit driven business that have considerable operating expenses to cover. As of now in healthcare industry, marketing is here to stay. We have to plan and execute some form of ethical marketing to remain in the field.

CONCERNS

Policies governing advertisement of medical personnel require clarity when it comes to the web.

Are the policies for individual practitioner only or include clinics and hospitals?

What are the rules of healthcare institution having website that provide information to patients amid health topics and even their services?

What kind of guideline online is permissible and what is deemed to be promotional?

Many of these questions are unanswered or partly answered; till such time debate rages on!

SUN PHARMA

In ocular discomfort due to dry eyes*

℞

Tear Drops

Carboxymethylcellulose Eye Drops IP (0.5% w/v)

In Diabetic Retinopathy

℞

GLOeye®

Bilberry Extract 80 mg + Pine Bark Extract 25 mg

Introducing

In management of Age related macular degeneration# and Diabetic retinopathy*

℞

I-site® AF

Lutein, Zeaxanthin, Vitamins and Minerals Capsules

Introducing

In Pain & Inflammation

℞

Nepalact®-Z

Nepafenac Ophthalmic Suspension 0.1%w/v

Data on file
* For temporary relief from burning irritation and discomfort due to dryness of the eye or due to exposure to wind or sun. May also be used as a

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2019 - 21

Group practice in Ophthalmology - A primer

An academic publication of KSOS for private circulation only