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EDITOR'S NOTE

Respected Seniors and Friends,

The most important aspect about our lives is our professional carrier's. We train ourselves for it through rigorous training. We are all familiar with Management. This is what we do with our patients- managing their disease.

However perhaps very few amongst us consciously use the managerial skills in building our practices. We know the adage- Change is the only constant, which can be paraphrased, with regards to ophthalmology as Change at 'lightning pace' is the only constant. Our specialty is in the midst of constant & dramatic change, to which we all have to adapt.

In this issue eminent authors have discussed some aspects related to Practice Management. You will agree that this is a vast subject in itself & hence we have tried to give snapshots of some important aspects of this subject.

We hope that you can get some useful tips by reading this issue on the most important aspect of our professional life- our practice.

I thank all the eminent authors who have contributed their articles in this issue.

Avery special thanks to Dr. A. K. Grover, President AIOS for writing a guest editorial.

I specially thank Dr. Parikshit Gogate, past editor of this journal, for helping in all aspects of this issue.

I also thank Dr. Medha Prabhudesai & Dr. Sucharita Paranjpe for their help in editing of this issue.

This is my last issue as Editor. I sincerely thank Poona Ophthalmological Society for giving me this opportunity. I hope I have lived up to the expectations of fellow members in maintaining the quality of the publication. I wish the august society all the very best for its future journey.

A team under the dynamic leadership of Dr. Jeevan Ladi has taken over the reins of the society. I am sure we will grow strong under his leadership & deliver sterling MOSCON 2011. I wish him & his team all the very best.

I also wish Dr. Medha Prabhudesai all the very best for her tenure as Editor of this journal and am sure we will have one of the best publication under her leadership.

I sincerely thank all advertisers for showing interest in advertising in this publication.

Warm regards to one & all.

Yours truly

Dr. Mandar Paranjpe
Editor, POSTER(2010-2011)

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Dr. A. K. Grover

GUEST EDITORIAL

Ophthalmic Practice scenario in India – present and future.

The practice of Ophthalmology has witnessed a sea change during the last decade or so, more so during the last 5 years. Let us see what those emerging trends are.

1. **More high-tech practice**
   Practice of ophthalmology is distinctly becoming high-tech where equipment is the king. It has therefore, become more cost intensive, making it more difficult for beginners to start their own practice
2. **Group practice**
   Partially as a result of the cost intensive nature of the private practice, group practice is increasingly catching up. The forms the group practice is taking in India is somewhat distinct from that in the west.
   The group practice is coming up in two forms
   a) Established or starting practices taking up subspecialists under a roof
   b) Groups sharing common facilities – more particularly equipment such as LASIK, perimeters and lasers etc.
3. **Emergence of Corporate Hospital**
   Corporate multispecialty hospitals have come up not just in metros but increasingly in grade B and C cities as well. This has been associated with increasing professionalism and commercial touch to practice, with possibly, a decreasing emphasis on personal, individualised care.
4. **Chains of private eye hospitals**
   Growth of chains of private eye hospitals is an increasingly visible trend which is having and will have a great impact on the way the speciality is practised.
5. **Marketing and advertising**
   Marketing has become an important buzzword with appearance of newspaper advertisements, hoardings and radio jingles.
   This trend is on the increase and is impacting the ophthalmologists in their own practice.
6. **Cut throat competition**
   Change in mind set from a more leisurely pace to a jet set mode, where cut throat competition is the norm and everything is fair in the quest for growth is an increasingly noticeable trend.

Challenges and how to meet them?

The changing trends offer both new challenges and opportunities. All of us must meet the standards of courtesy and hospitality set by the corporate hospital and chains of hospitals. Maintenance of a higher level of quality both in management and in professional services has acquiredanurgency. One needs the best financial managements practices. The use of professional management principles is possibly the way forward.

However the biggest challenge will be maintenance of the highest standards of ethics and commitment to patient welfare with personalized humane care in the face of the new changed milleu

Can we do it, is the real question, whose answer is manifold.

I wish this issue of POSTER all the very best.

Warm Regards,

Dr. A. K. Grover
Hon. President, AIOS (2011-2012)

Incoming President's letter

Dear Members of Poona Ophthalmological Society,

I am honoured to take over as President of our esteemed society from 3rd April 2011. The forthcoming year promises to be an eventful one with lot of activities planned.

I am thankful to the Managing Committee of POS for accepting my proposal for accreditation of our CMEs from Maharashtra Medical Council. The proposal was accepted and for the first time the annual conference of POS in December 2010 was accredited with 4 credit hours by the MMC. As per MMC guidelines, we all are supposed to collect 30 credit hours in 5 years with a maximum of 12 credit hours in one year. We are trying our level best to provide more than 12 credit hours in the forthcoming year 2011-2012. Our plan is to hold one CME per month with our best efforts to get MMC accreditation for most of the programmes. For details and updates visit www.pospune.com

We also plan to combine our clinical meetings with Mini Symposium. This will help authors who are presenting clinical cases to get a large audience as well as exposure to present before imminent guest faculty. We would like presenting authors either PG students or POS members to represent themselves at national and international level.

As you are all aware, we are holding MOSCON 2011 at Marriott International Convention Centre in Pune. We are fortunate to have the largest such centre in West India at our disposal with its state of the art facilities to conduct a mega conference. As hosts, all POS members are requested to contribute by telling their friends in Pune, Maharashtra and India to register for MOSCON and grace the occasion. You are also requested to speak to Medical Representatives of various companies who come to your setup to contribute to the conference by way of major sponsorship, audio-visual sponsorship, sponsoring different events, taking stalls etc. Though our trade committee, all members of LOC and other POS members are working very hard, a few kind words from you will definitely boost our cause in acquiring sponsors.

I am thankful for the enthusiastic and overwhelming response shown by all POS members in working for MOSCON 2011, Pune to make it a success. Our official website is now functional; members are requested to visit www.moscon2011.com for registration, online payment, updates and other details. It is for the first time that a dedicated website has been developed (for the MOS annual conference) for the benefit of delegates with the facility of online payment. All 4 major websites are now interlinked for MOSCON2011, Pune: www.moscon2011.com, www.pospune.org, www.moseye.org and www.boamumbai.com

I welcome suggestions from all members for the betterment of our society, planned activities and conferences. You can call me on 9766163623 or e-mail me at jeevanladi@gmail.com anytime you wish.

I look forward to working with all of you.

With warm and sincere regards,

Dr Jeevan Ladi
Hon. President
POS (2011-2012)

Know your President

Dr Jeevan Ladi completed his MS, DOMS, DNB in Ophthalmology from the KEM Hospital in Mumbai with gold medal in MS. He has been practising in Pune as a consultant Ophthalmologist since 1991.

He has a special interest in Phacoemulsification and refractive surgery and has pioneered techniques in both. He was one of the first to introduce Phacoemulsification surgery in Pune in 1994 as well as started the first topical Phaco in 1996. He pioneered the technique of "Epinucleus Mode Phacoemulsification" and "Ultrasound Chop in Phaco" presented at the ASCRS , USA. He was also the first to perform CTR surgery with the Morscher ring in 1996 and the Cionni Modified CTR in 2001 in Pune.

He has been doing refractive surgeries since 1991 and is one of the few surgeons to have worked on all Excimer laser platforms. He has done fellowships with Dr Theio Seilar, Switzerland in Femtosecond Laser, with Dr Arturu Chayat**,** USA and with Dr Arun Gulani**,** Florida, USA. He also has extensive experience in other refractive procedures like phakic IOLs – Iris claw and Implantable Contact Lens (ICL); Pre Lex: Presbyopic clear lens extraction with Multifocal IOL; presbyopic CustomVue Lasik; pseudophakic CustomVue Lasik for residual refractive error; Corneal Collagen Cross linking (C3R), and INTACS. He is the first surgeon in India to install the Galilei Dual Scheimplug Analyzer in his institute in 2008. He published peer reviewed research paper on the Galilei analyzer (comparing Corneal thickness measurements between Galilei and Ultrasound pachymetry). This is the first research paper on Galilei in Asia and only the second in the world.

He performed 4 point scleral fixation IOL as early as 1991 and followed it with a number of difficult cases for secondary IOL implantation. He was recipient of the prestigious Dr V K Chitnis Oration award given by Maharashtra Ophthalmological Society (MOS) in 2004 for "exemplary work" in secondary IOL implantation. He is also the recipient of Bell Pharma award and prize for Best Video on "Phacoemulsification in complicated cases" given by MOS.

He has been invited as a guest speaker at various state, national and international conferences. He has also demonstrated live surgery in Phacoemulsification at numerous conferences. He has presented 12 papers and many videos at national and international conferences. He is also invited faculty for AIOS.

He is currently Chairman Scientific Committee of Maharashtra Ophthalmological Society.

He is married to Dr Sushma Ladi who is Professor in department of Anaesthesiology at Bharti Hospital and Medical College. She passed her MD with Gold Medal from Aurangabad medical College. She has passed 6 classical singing examinations with "Sangeet Visharad Pratham". They have twin daughters Ms Krutika and Ketaki who appeared for their 10^{th} class ICSE examination from St Mary's school this year. Both have passed "Karate Black Belt". They have also passed 6 "Bharatnatyam" examinations and are due for their "Arangetram".

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M.B.B.S., F.C.P.S.
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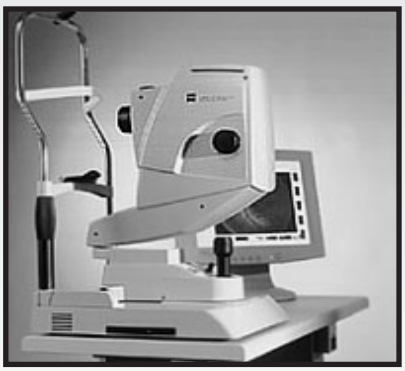
- **Oculoplasty Surgery including Endonasal, Endoscopic Dacryocystorhinostomy**



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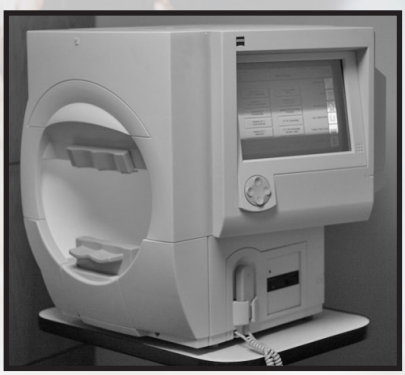

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Visit us at : www.paranjpeeyecare.net ● email: contact@paranjpeeyecare.net

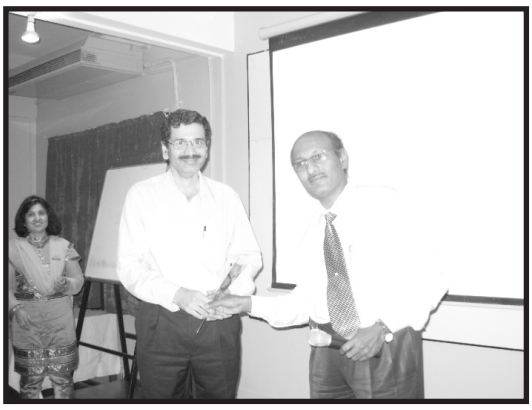
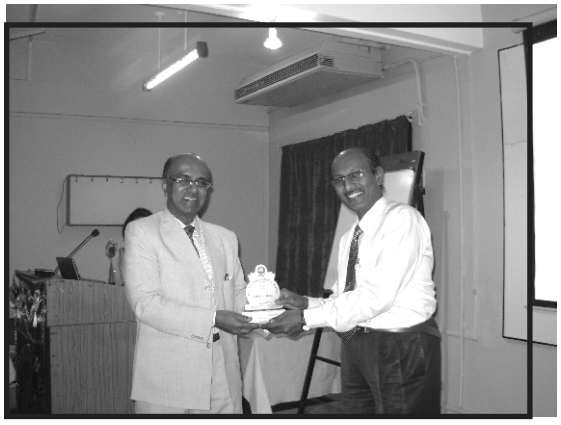
Poona Ophthalmological Society
3rd Annual Conference, December 2010



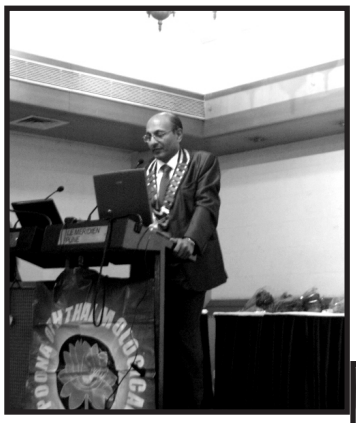





Clinical Meeting at KEM Hospital

Clinical Meeting at Deenanath Mangeshkar Hospital

AGM

Secretary's Annual Report & Photo of Programmes (Dec-March)

Dr. Geetanjali Sharma (Kasmalkar)
Hon. Secretary

It gives me immense pleasure writing to you my report. Working as Hon. Secretary of POS for the year 2010 – 11 was really an honor. It was a challenge taken by putting a lot of hard work , using organizing skills and team efforts. At the end of the day it was a great learning experience and a very satisfactory feeling.

Scientific Programmes :
It was a year full of academics for we organized nearly 2 programmes every month. There were live surgical workshops, Clinical meetings, Live Demos, Quiz competitions, Symposia, CMEs, one day conferences and the cherry on the cake was the 3rd Annual Conference of POS. The conference was appreciated by one and all. The chief Guest Padmabhushan Dr Noshir Shroff and all the guest faculty have specially appreciated the efforts taken for organising this conference.
A total 23 programmes were organized in this year.
AGM will be the 24th event

POS Accreditation By MMC :
The greatest achievement of this year was to get POS accreditated by the Maharashtra Medical Council for 5 years. Any scientific programme by POS is henceforth eligible for the credit points by the MMC.
The Third Annual Conference of POS was granted 4 credit hours by the MMC

POS Quiz was another very interesting activity by POS. There was a year long competition as well as quiz sent by e mails to all members. The winners of the Annual Quiz were given a big trophy at the annual conference while the winners of the e mail quiz were felicitated at the clinical programmes.

Peer reviews and Feedbacks :
One important feature I followed for all the programmes was to get the Peer reviews and Feedbacks from the delegates for all the programmes that we organized. That gave me a chance to understand the lacunaes , shortcomings and suggestions to improve for the next programme. I must thank all the peer reviewers and the POS members who actively participated and helped me to improve the standard of the programmes. I express my gratitude to all the head of the departments at various institutes who gave their suggestions and advises on various issues. I thank them all for their help in organizing programmes at their respective institutes.

POS WebSite :
www.pospune.org was launched last year. It was made a Dynamic WebSite this year. Now we can upload videos, interviews, interesting cases and achievements etc immediately on the web site. The website is now managed by ourselves and not by the vendor. The website committee worked very hard to make this a dynamic website.

POSTER : The Journal of POS :

3 Issues have been published in this year. They are the Retina, the Souvenir of Annual Conference which included scientific articles on various topics and the Practice management issue which will be released during the AGM.

The issues are also available on the website. The scientific content of the POSTER is of the standard of National or International journal. The whole credit goes to Dr Mandar Paranjpe, the Editor.

POS trekking Club :
This brain Child of Jt Treasurer Dr Baban Dolas was officially inaugurated on 20th June 2010 at the hands of

children of SAMPARC Balgram. Sweets and stationary were distributed to children of Balgram. The first trek was from Bhaje caves to Lohgad Fort. The next trek was to Shivnerifort and Malshej. Free eye camp and Spectacle distribution was done at the foot hills of Shivneri fort for the tribals in this area.
POS members Dr Baban Dolas, Dr Sameer Datar and team went cycling to MOSCON from Pune to Sangli and gave the Message of Eye Donation in the cycle rally.

POS was appreciated by Dr Natarajan at the AIOC, Ahmedabad as the most happening society.
He appreciated the work done by the Hon secretary and the managing committee. I was nominated by the MOS for the Leadership Development Programme by AIOS for the year 2011.

Many POS members who have done proud to our society by achieving success at national and international level. Lt Gen Vats was awarded PVSM. Col Dr Madan Deshpande has been elected as President of INACO. Dr Jhamwar was awarded at INACO, Kolkata for his exclusive work in squint camp. Many members of our society got elected on the managing committee of MOS. Many of our members were invited as Faculty at various national and international conferences. It feels good to be the Secretary of such an excellent society.
I wish to express my heartfelt sorrow and condolences to the families of our members who lost their dears and nears. We have lost 2 senior members Dr Prof. A. B. Das and Dr Vijay Bendale. POS salute their contribution to the society as Ophthalmologists.

The programmes organized this year are as follows :

1. 16th April 2010 : Clinical Meeting at National Institute of Ophthalmology
Speaker : Dr Shreekant Kelkar : Bird Photography
Cases discussed : 1. CMV Retinitis: Dr Shilpa Bhirud, NIO
2. Congenital Glaucoma : Dr Sarita Bhandari, NIO
3. Toxoplasma Chorioretinitis : Dr Sayali Pradhan, Deenanath Mangeshkar Hospital

2. 8th and 9th May 2010 : Eye India Conference: HV Desai Eye Hospital under aegis of POS. Conference on Comprehensive Ophthalmology withLive surgeries

3. 23rd May 2010 : Squint Symposium : Hotel Ambassador
Guest Speaker : Dr Santham Gopal, Bangalore : Overview of Squint
Panelists : Dr Milind Killedar, Dr Abha Kanade. Moderator : Dr Jai Kelkar

4. 5th June 2010 : UBM and USG B Scan : Live Demonstration : Ruby Hall Clinic
Guest Faculty : Dr Deepak Bhatt, Mumbai.

5. 12th June 2010 : Retina Update : Hotel Deccan Rendezvous

Guest faculty : Dr Vatsal Parikh, Mumbai, Dr Nitant Shah, Dr Nitin Prabhudesai, Pune

6. 27th June 2010 : POS Championship Quiz : Elimination Round : Poona Hospital
Guest speaker : Lt. Gen. Vats : Management of Fungal Keratitis

7. 11th July 2010 : Refractive Symposium : Hotel Orbette
Speakers : Dr Vaishal Kenya, Mumbai, Dr Vasant Sapowadia, Jamnagar Dr, Jeevan Ladi, Dr Suvarna Joshi, Dr Madhuri Chandorkar

8. 18th July 2010 : Facial Aesthetic Surgery Meet with Live surgery Workshop : Smt Kashibai Navle Hospital and Medical College (Oculoplasty Workshop)
Faculty : Dr Milind Naik And Team, L. V. Prasad Eye Hospital, Hyderabad

9. 29th Aug' 2010 : Neurophthalmology Symposium : Bharadwaj Auditorium, AFMC .
Faculty : Dr Rashmin Gandhi, Sankara Nethralaya, Chennai, Bri. Banarji, Col. Gurunadh, Col. Vikram Khanna
Cases Discussed : 1. Unilateral Hemianopia : Lt. Col. Santosh Kumar
2. Bilat. Optic Neuritis : Lt. Col. Santosh Kumar
3. Optic Neuritis : Dr Mamata Deshpande
4. Bilat Optic Atrophy : Kawasaki's Disease : Dr Geetanjali Sharma

10. 4th and 5th Sept 2010 : Uveitis Conference :
Organised by NIO under aegis of POS : YASHADA Auditorium, Baner Rd, Pune
Faculty : Dr Vishali Gupta, PGI Chandigad, Dr Jyotirmay Biswas, Sankara Nethralaya, Dr Winfried Amoakau, UK, Dr Padmamalini, Bangalore, Dr Pran Nagpal, Ahmedabad, Dr Vinita Rao, Dr NSD Raju, Vice President AIOS.
Moderator :Dr Udayan Dixit, Dr Aditya Kelkar
Cases presents By POS members : Dr Bijlani, Dr Geetanjali Sharma, Dr Parag Apte, Dr Arati Palsule.

11. 19th Sept 2010 : Glaucoma Symposium : Hotel Coronet, Apte Road
Faculty : Dr Sunil Jain, Mumbai, Dr Medha Prabhudesai, Dr Shraddha Satav, Dr Sagarika Patyal, Dr Tejaswini Walimbe

12. POS Championship Quiz : Semifinals : Masters Dr Bijlani, Dr Nitin Prabhudesai

13. 26th Sept 2010 : Live Surgery Workshop : Refractive and Defractive IOLs: Kamal Netra Rugnalay (Dr Sudhir Kale's Hospital)

Faculty : Dr Sharad Patil, Nasik, Dr Kumar Doctor, Mumbai, Dr Ladi, Pune, Dr Sachin Kale, Pune, Dr Kishore Pahuja,

14. 21st Nov 2010 : Glued IOL conference : Live surgery : Organised by NIO under aegis of POS

Faculty : Dr Amar Agarwal, Dr Mohan Rajan, Chennai, DrHaldipurkar, Panvel, Dr Yogesh Shah, Dr Ashish Nagpal, Dr Lahane, Dr Ragini Parekh, Mumbai

15. 18th and 19th Dec 2010 : 3rd Annual Conference of POS : YASHADA, Baner Road, Pune

MMC had granted 4 credit hours to delegates and 5 to faculty

Faculty :PadmabhushanDr Noshir Shroff : New Delhi, Dr Kim and Dr Usha Kim, Aravind Eye Hospital, Madurai, Dr Milind Naik, Dr Ramesh Murthy, Hyderabad. Dr Haresh Pathak,

POS members actively participated by presenting cases and presenting their papers.

16. 8th Jan 2011 : Glaucoma Symposium : Hotel Deccan Rendezvous, Apte Road, Pune

Faculty : Dr Sunil Jain, Dr Rupali Nerlikar, Dr Tejaswini Walimbe, Dr Kalyani, Dr Vidya Cherlekar and Dr Medha Prabhudesai

Moderator : Dr Geetanjali Sharma

17. 27th Jan 2011: Clinical Meeting : KEM Hospital, Pune

Guest talk :Dr Suresh Shinde : Thrombolysis for CRAO : New treatment modality and 6 Cases presented by POS members : Dr S. Shah, Dr Prachi, Dr Sameer Datar, Dr Mandar Paranjpe, Dr. Lt. Col. Santosh Kumar

18. 18th Feb 2011 : Clinical Meeting : BJMC and Sassoon Hospital, Pune

Speaker : Dr Prashant Dhakephalkar : Biotechnology in Medicine: Application and achievement.

4 cases presented by POS members : Dr Bastawade, Dr Mehta, Dr Varsha and Dr Tanmayee

19. 19th March 2011 : Clinical meeting : Deenanath Mangeshkar Hospital

Guest talk :Dr Ramesh Murthy : Overview of Ocular oncology and oculoplasty and Case presentation by POS members

20. 27th March 2011 : Clinical meeting : BharatiVidyapeeth Medical College, Pune.

Guest Talk :Dr Ruchi Kabra: Surgical management of Orbital SOLS and lid tumors and Case presentation by POS members

21. 3rd April 2011 : AGM : Hotel le Meridian

POS Trekking Club Activities

22. 20th June 2010 : Laugural trek to Lohgad and Bhaje. Inauguration at hand of children of SAMPARC Balgram . Sweets and stationary were distributed to children of Balgram

23. 22nd August 2010 : Trek to Malshej and Shivneri with Free Eye Check Up and spectacle distribution to tribals.

24. POS Ophthacricket : Cricket matches are organized by POS every year. This year the matches were organized on 28th Oct 2010 at Poona Club. Dr Ketan Jathar, Dr Damle and Dr Mrs Muthiyan got the awards! Dr Ketan Jathar took a lot of efforts to make this successful.

Thus it was really a very active and happening year of POS. Organising so many programmes was a great challenge for me. I could mange it with help of the managing committee members and various institutes in Pune. I wish to thank AFMC, Sassoon Hospital and BJMC, Navle Hospital and Medical College, Bharati Vidyapeeth Medical College, NIO, KEM, Deenanath Mangeshkar Hospital and H V Desai Eye Hospital for all the help. All the past presidents and advisors helped me at every level. The managing committee, The scientific committee, my teachers and all my friends in POS were always there for me when I needed their help. It was a great team work throughout the year.
We had 17 EC meetings and many more Core Committee and Sub committee meetings to organize all the programmes.

More than 50 new members have joined POS this year. This too is one of the highest numbers in last few years. I welcome the new members to POS family. I believe POS has become popular among the Ophthalmologist fraternity not just in Pune but even outside.

POS is organizing MOSCON in October 2011. I feel proud to say that POS is ready with the foundation and ground work so that we can organise an excellent MOSCON 2011.

I thank you all once again for giving me the responsibility of Hon secretary and helping me to make it successful.

I wish the next managing committee all the success and wish POS to progress by leaps and bounds!!

Thanking you!

Yours Truly

Dr Geetanjali Sharma (Kasmalkar)
Hon. Secretary, 2010-11

CONDOLENCES

Poona Ophthalmological Society express deepest condolence on the sad demise of following members, family members of POS members

Dr Prof. A B Das, Former HOD, Ruby Hall Clinic & AFMC, Pune

Dr. Vijay Bendale, Consultant Ophthalmologist, Pune

Dr Jayant Deodhar, H/O Dr. Vaijayanti Deodhar, Past-President, POS

Dr K B Grant, Founder Chairman, Ruby Hall Clinic, Pune

Mr Bhausaheb Jhamwar (Father of Dr Jhamwar)

Mr Ramanlal Shah (Father of Dr Nandkumar Shah)

Mother of **Dr. Ravindra Kolte**

Mother of **Dr. Paras Shah**

Mother of **Dr. Sanjay Savarkar**

Father of **Dr. Madhusudan Kumbhare**

Mother-in-law of **Dr. Anushree Desai**

Member's Achievement

Dr Brig Tejindar Ahluwalia was Awarded the Chief of Army Staff Commendation Card in January 2011. He is promoted to the rank of Brigadier w.e.f 01 January 2011 and joined as Prof & Head of Dept of Ophthalmology at AFMC w.e.f 01 April 2011.

Dr Piyush Ramesh Bansal was selected to present his thesis research work on diabetic retinopathy at the Academic research committee session at AIOC 2011 Ahemdabad and was felicitated by Hon. President of AIOS Dr R V Azad for excellence in research .

Dr Nikhil Beke, (S/O Dr. Neelima & Dr. Nandkumar Beke), passed his MS, Ophthalmology Exam, from PGI, Chandigarh, with a Gold Medal in May 2010.

Dr Sameer Datar: Awarded Best video award MOSCON 2010 Sangli - on Boston Keratpprosthesis

Dr Col Madan Deshpande: Elected as President of Indian Association of Community Ophatholmology (INACO)

Dr Rahul Deshpande invited in Malaysia (Kuala Lampur) in Internation Low vision Confernce to Chair 1 session as co-chariman on 22nd Feb. 2011.

Dr Baban Dolas: was selected for Leadership Development Program by ARC, AIOS from Maharashtra & successfully became LDP graduate. He is a also member of LDP Alumni of American Academy of Ophthalmology.
Received Padmashree Manibhai Desai National Service Award for community work in Ophthalmology.
Dr Baban Dolas, Dr Sameer Datar and others Participated in the Cycling trip from Pune to Sangli to Create awareness about Eye Donation..

Dr Parikshit Gogate Invited to teach at the Congenital Cataract Symposium organized by the Emory University in New York in March. The symposium was organised by the Emory School of Medicine and held at the Yale Club, New York. The symposium aimed to reach out to pediatric ophthalmologists in the United States to improve outcomes of congenital cataract surgery. Dr. Gogate is the only invited speaker from India.
Taught in Oman, Cambodia
Indian Journal of Ophthalmology 'Silver' award for the Best Letter to Editor for 2010, Comparision of BSS plus vs ringer lactate
Presented four papers at the ISGEO, World Ophthalmology Congress, Berlin 2010.

Dr Col R P Gupta: Delivered a lecture on " Blast injuries affecting orbit in war, insurgency & Terrorism" in my No 1 Pearl in Orbit session at Annual Conference of AIOS at Ahmedabad on 06 Feb 2011.
Peeyush Gupta s/o Dr (Col) R P Gupta completed MBA from prestigious B School of this country "IIM Ahmedabad" and has been placed as Associate Manager in Infosys Technologies at Toronto (Canada).

Dr Ketan Jathar was invited as a faculty to speak on Anti-VEGF's in DME in the debate session at MOSCON 2010, Sangli.
Secured runner up position in Lawn Tennis Doubles event in the annual sports event conducted by IMA

Dr M B Jhamwar : Awarded Best paper: INACO .
Included in Limca Book of Records for highest number of squint surgeries in two consecutive squint camps.

Dr Aditya Kelkar: Delivered Key Note address at West Bengal Society Annual Conference
Conduct Eye Surgery at Bombay Ophthalmic Association Annual Conference

Invited as Guest Faculty at All India ophthalmological Society Annual Conference at Ahmedabad
Presented Retinal Surgery Video at European Vireo retina Society conference, Spain
Presented Retinal Surgery Video at VRSI
Invited Guest Speaker at Annual IIRS India conference, Chennai
Published Article on CMV retinitis accepted for publication in peer reviewed journal-Ocular Inflammation and Infection
Conducted Uveitis conference and Glued IOL conferences in Pune under aegis of POS
Selected on Editorial board of VRSI news letter
Appointed Reviewer for Indian Journal of Ophthalmology

Dr Jai Kelkar: Invited as Guest Faculty-MOSCON 2010,Sangli
Invited Guest Faculty AIOC 2011, Ahmedabad
Invited Guest speaker at IIRS India,Chennai
Elected as Executive Committee member in Strabismological Society of India
Conducted Squint seminar under Aegis of POS
Co-author in Article on CMV retinitis accepted for publication in peer reviewed journal Ocular Inflammation and Infection
Conducted Uveitis conference and Glued IOL conferences in Pune under aegis of POS

Dr Jeevan Ladi: Published first study in Asia and only the second in the world till September 2010, titled "Comparison of central corneal thickness measurements with the Galilei dual Scheimpflug analyzer and ultrasound pachymetry." Jeevan S Ladi, Nitant A Shah. Indian J Ophthalmol: 2010;58:385-388
Nominated as Chairman Scientific Committee: MOS 2010-2012
Invited Faculty: Sangli, Kolhapur and Nasik. Instruction course and faculty at MOSCON 2010, Sangli.
Live surgery and Guest Faculty: Live Lasik surgery at Sir J J Hospital organized by MOS, BOA and live phaco surgery in complicated case with guest faculty at Ganapati Netralaya, Jalna
Judge for free papers: Gujarat Ophthalmic Society Annual Conference
Faculty at AIOC 2011, Ahemadabad

Dr Sanjeevani Mahajan was felicitated by mayor of Pune Shri Mohansing Rajpal on 26th Jan 2011 in appreciation of her social work.

Dr Prakash Marathe Invited at Sangli MOSCON 2010 as Moderator for Ophthalmological Debate,.
Elected as Managing Committee Zonal Member for Maharashtra Ophthalmological Society,
Elected as Managing Committee Member for Indian Medical Association, Pune (2011-2014)
Elected as Joint Secretary for Indian Medical Association, Pune (2011-2012)

Dr Supreet Marathe (S/O Dr. Prakash Marathe) M.S. (Gen. Surgery- Registrar, Seth G. S. Medical College & KEM Hospital Mumbai)
Received Third Prize for Scientific Poster amongst 171 Posters by practicing Surgeons & PGs at Maharashtra State Surgical Conference, MASICON 2011, Mumbai

Dr Madhavi Mehendale Published her book 'Daivi Pratibhecha kalavant Michelangelo' on 6th of March 2011.

Dr Vijay Mohite elected president, Rotary Club of Pune, Hadapsar for 2011-12

Dr Mandar Paranjpe was invited as a judge for 'Video Film Contest' at MOSCON 2011 at Sangli.

Dr Rajesh Pawar: Participated as Surgeon, for second time in Mega Squint Surgical Camp in August 2010 in which a total 157 squint surgeries were done, a new Limca Book Of Records.

On 1st and 2nd January 2011-Special Appreciation of Free Squint Surgery Camp in Baramati by Agricultural Minister of India Hon. Sharadchandraji Pawar

On 12th Dec 2010 Special Felicitation at the hands of Deputy Chief Minister of Maharashtra Hon. Ajitdada Pawar for dedicated work in Community Eye Care through Baramati Mitra Mandal.

Special recognition for at the hand of Hon M.P. Mrs. Supriyatai Sule during Mega Health Camp at Bibwewadi in Dec. 2010.

Lt Col (Dr) Santosh Kumar sucessfully passed the final part-3 advanced clinical examination of the International Council of Ophthalmology (FICO) in Dec 10.

Successfully passed the fellowship examination of the All India Collegium of Ophthalmology (FAICO - Cataract & Phaco) in Jan11.

Successfully passed the fellowship examination of the All India Collegium of Ophthalmology (FAICO - Comprehensive Ophthalmology) in Jan11.

Dr Geetanjali Sharma : Was presented with Dr Madhusudan Jhamwar Award for scientific excellence, community work and organizational skills by POS, during 3rd POS Annual Conference, 2010.

She was Invited faculty at INACO, International conference of Community Ophthalmology, Kolkata. She was also co chairman for the free paper session during this conference.

She has been Nominated by MOS for LDP (Leadership Development Programme) of AIOS.

Rutwik, Son of Dr Sharma ranked first in Pune Boys for ICSE 2010.

Pranjali, Daughter of Dr Sharma ranked first in 2nd MBBS exams of MUHS in B J Medical College with distinction in Pathology and Microbiology

Dr Prasad Walimbe : Published text book titled “STEP BY STEP SQUINT SURGERY” (published by Jaypee Medical Publishers, New Delhi) was officially released in recently concluded All India Ophthalmlogical Society Conference at Ahmedabad. He has donated the author’s royalty from the book to “Poor Children Spectacle Fund-Aravind Eye Hospital, Madurai”.

Invited as Faculty member for plenary session on squint at MOS conference, Sangli, Oct. 2010. He gave 2 lectures (Pediatric Cataract Surgery & Wound Construction in SICS) and 2 videos at MOSCON, 2010, Sangli.

He convened a Squint Symposium at Bombay Ophthalmologists Association 2010 Annual Conference.

Dr Lt Gen Vats : Awarded Param Vishistha Seva Medal (PVSM) by President of India

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ETHICAL ISSUES IN OPHTHALMOLOGY

DR. ANIL KULKARNI, M. S.
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Doctor Patient Relationship:

When an individual seeks the professional services of a physician, in this case, an ophthalmologist, and the surgeon knowingly accepts the patient, the physician patient relationship starts and the ophthalmologist owes the patient proper care.

The physician has no legal duty to accept any person as a patient, however the decision to refuse may not be made on the basis of discrimination for race, creed, colour etc. Objective grounds for refusing the patient can be in case where the eye surgeon feels that his level of knowledge and training in that particular case is inadequate to maximize benefits to his patients for example eye injury with head injury or history of un-consciousness, where neuro-surgical assistance may be of life-saving importance with the eye trauma having a secondary role.

To maintain confidentiality of patient related information is an ethical and legal obligation.

A doctor is trained to heal. He is less trained to debate, argue or do paper work for various legal requirements. He is compassionate but busy, cares for the patient but does not express it openly, feels the sufferings of the patient but does not sympathize in front of him. All this puts him in a vulnerable position whenever the results of his management are less than desired or the anticipated cure is not achieved for no fault of his. When it comes to an unhappy patient the demi-god status suddenly changes into that of an adversary and it comes as a rude shock to the eye surgeon.

Code of Ethics :

A copy of code of medical ethics is given by the registrar of the council to each applicant at the time of registration. Some of these regulations are:

1. Solicitation of patients directly or indirectly by a physician or by institutions is unethical.
2. Advertising and publicity through lay channels, to invite attention to himself for self benefit, endorsement of any products or articles and boasting of cases or cures through lay channels is also unethical.
3. A physician should not give, solicit or receive any gift or commission in return for referring or procuring any patient for treatment.
4. A physician may patent surgical instruments, appliances and medicine or copyright applications, methods and procedures. However, it shall be unethical if the benefits of such patents or copyrights are not made available in situations where the interest of large population is involved
5. Physicians should try continuously to improve medical knowledge and skills and should make available to their patients and colleagues the benefits of their professional attainments.
6. Every physician shall maintain the medical records pertaining to his / her indoor patients for a period of 3 years from the date of commencement of the treatment in a standard proforma
7. Every physician should, as far as possible, prescribe drugs with generic names and he / she shall ensure that there is a rational prescription and use of drugs.
8. A Physician should expose, without fear or favour, incompetent or corrupt, dishonest or unethical conduct on the part of members of the profession.
9. The physician, engaged in the practice of medicine shall give priority to the interests of patients. The personal financial interests of a physician should not conflict with the medical interests of patients. A physician should announce his fees before rendering service and not after the operation or treatment is under way.
10. Physician rendering service on behalf of the state shall refrain from anticipating or accepting any consideration.

Un ethical practice:

A physician who studies one system of medicine, but practices another is a quack and guilty of medical negligence and such a service provider is held guilty without further proof to hold him liable for his actions.

A quack has been elaborately and suitably

defined as a person who pretends to have knowledge which he does not possess; who promises to do what he is either not sure he can perform or what he is certain he cannot perform; who represents his practice to be more successful than that of other men; who pretends to cure diseases known and admitted to be incurable; He is addicted to handbills, newspapers and similar modes of making known his pretensions and proceedings. This is the quack and the conduct of this man is quackery.

The Unhappy Patient:

The realization that patients are not satisfied by visual results alone is evident. With advances in the eye care system, excellent visual results are taken for granted and the satisfaction of the patient depends on other factors which include, staff behavior, waiting time, doctor's concern towards minor complaints etc. When in addition to these possible irritants where the expectations don't meet the services, the visual result is also less than anticipated, the patient becomes unhappy.

If a rational, believable and compassionate explanation and approach is adopted, the eye surgeon gets the benefit of doubt, if not; the patient decides to go elsewhere which could mean another eye surgeon or more ominously a lawyer. Communication is often the key word that could prevent many such complaints and mishaps. The patient often goes to the court because he / she feels that they have not been listened to properly. In spite of having done justice to the problem or disease at hand, a doctor may leave the patient with a feeling that enough time \attention was not given. Thus the following guidelines of behavior may be of importance.

- Listen attentively, examine carefully and record everything as far as possible
- Oblige the patient by re-examining if he / she is very insistent
- During consultation, non-urgent phone calls should not interrupt the examination
- Employ qualified assistants who know what they are doing
- Don't do anything beyond one's level of competence
- Be honest with the patient, always. False assurances and incompetence always gets caught because the results of treatment in such cases are usually unsavory.
- Comments or body language of the second consultant to whom the patient may have gone for a second opinion affects the patient deeply. Criticizing others to advance oneself, is a boomerang which ultimately hurts. Giving a sound opinion and suggesting further management never requires discrediting the other surgeon. Consideration of collegiality is an essential part of ethical code.

Counseling the patient prior to treatment to ensure that the patient's expectations are realistic is an integral part of the doctor patient relationship. It is important to discuss the pros and cons of every facet of treatment suggested. Assuring 100% results for any surgical procedure, giving lifelong guarantee for any device being used, committing to recovery of vision to 6/6 or beyond by refractive surgery, zero refractive error after LASIK and other such examples of near perfect results raise the expectation levels in the patient to un-realistic levels and leaves the patient unhappy, if his/her expectations are not satisfied.

It is surprising to notice how often patients may decide against filing a suit even when there is cause for legal action. Providing realistic expectations about possible outcomes, respectful and competent behavior on the part of the treating physician, and openness to communication are the golden keys to the establishment of a long-standing and trustworthy physician-patient relationship.

Any comments or actions, which can be interpreted as disrespect to the patient or his relatives need to be avoided.

Altering the records of the patient is unethical, always looked down by the judge and suggests prima facie guilt of the doctor.

Acts of Omission:

Certain actions that may cause harm by the very fact that they were not performed, when they should have been performed as per standard official protocols for the same, comprise acts of omission. Some of such (in)actions are:

- Failure to perform essential tests before surgical procedure.

e.g. in traumatic cataracts or complicated cataract, B scan USG is necessary to rule out retinal involvement and the anticipated poor prognosis needs to be mentioned before the surgery is undertaken. In perforating injury of the eye, X ray of orbit needs to be taken, to rule out Intra ocular foreign body even though the suturing has been done earlier as an emergency procedure.

- Failure to give appropriate information to the patient regarding his/ her clinical condition.

  e.g. possible non recovery of vision in grievous eye injury needs to be explained to patient or relative and mentioned accordingly on the patient record. Similarly, a patient of fungal corneal ulcer needs to be aware that even after the ulcer heals, there will be a corneal scar which might affect his vision. If the presence or the absence or the presence of these findings is not recorded by the eye surgeon at the time of initial examination, it comprises an act of omission.

- Failure to obtain second opinion from another competent eye surgeon before undertaking destructive procedure of the eye like Enucleation or Evisceration, e.g. Suspected Intraocular tumours, pan ophthalmitis , trauma with uveal incarceration to prevent sympathetic ophthalmia etc. It requires two competent and qualified eye surgeons to agree to authorize destructive procedure on any eye.

- Failure to give appropriate advice or instructions after surgery regarding precautions to be taken or medicines to be instilled is an act of omission.

- Failure to maintain aseptic conditions in the operation theatre is an act of omission.

Acts of Commission:

These are actions that may cause harm by the fact that they are performed, when they are not required to be performed as per standard official protocols for the same and irrespective of the suggested personalized reasons given by the eye surgeon for having performed it which at times includes teaching purposes. Acts of commission are more serious than acts of omissions and some of them may even have consequences suggestive of a criminal act. Some of such actions are:

- Performing an operation when not indicated is an act of commission for which the eye surgeon may be criminally liable. Some examples of these would be operating a patient for cataract in the absence of any such changes when patient feels his/her headache will be cured by the surgery (deliberate mis-information), removing cataract in patient with no perception of light or absolute glaucoma, doing glaucoma surgery for ocular hypertension, creating a posterior capsular rent in order to practice vitrectomy etc. Operating on patients with absolute glaucoma is often done under the aegis of teaching purposes, which is totally unacceptable. Similarly, inserting an IOL that has fallen on the ground or an unsterile area even after cleaning it comprises an act of commission.

- Using certain drugs without ascertaining its contraindications or patient's history of sensitivity to it;

  e.g. using Acetazolamide for patient who is allergic to sulpha group of drugs, using phenylbutazones in patient who had a history of skin lesions following the similar drug ingestion earlier is an act of commission as these drugs may actually harm the patient.

- Implantation of a wrong IOL and leaving the patient with large ametropia, implanting aspherical or multifocal lens with the anterior surface placed posteriorly, inserting posterior chamber IOL in anterior chamber due to PC rent on table, implanting an IOL with broken haptics which results in subsequent decentration, inserting an ACIOL in dense nucleus drop case etc are all acts of commission.

- Operating on a wrong eye due to accidental instillation of preoperative mydriatic in other eye, confusion in resection and recession of extra ocular muscle during squint surgery, probing under GA done on wrong side and performing a destructive procedure etc is an inexcusable act of commission.

- Operating on a patient even when poor prognosis is anticipated and more harm is done by the procedure like trying to remove a cataract or doing filtering procedure in absolute Glaucoma and resulting in expulsive hemorrhage, doing LASIK when the corneal thickness is less than optimum and results in corneal ectasia, doing keratoplasty in heavy corneal vascularization and secondary glaucoma resulting into staphyloma and blind eye etc.

In summary, it is important to be aware of the legal, ethical and moral issues regarding medicine. All medical practitioners including eye surgeons are a privileged group. The responsibilities that come from these privileges should not be ignored. Truly caring for the patient, being honest, providing competent care and respecting the patient is the best way to avoid legal suits and is also the best way to practice, globally!

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USEFUL TIPS FOR SUCESSFUL PRACTICE

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Success is not a destination but an on-going journey. -Anno.

In the days of intense competition, every practitioner aims to be one of the best in their region. However it's only few who achieve significant or remarkable success.

In this article I have put forth some of my personal observations gathered over last 30 years of my practice, which some of the readers may find useful in building a successful practice. Since these are my personal views, the reader may differ from some or all of these suggestions.

I will discuss this topic under following headings

- **How much to charge and how much concession is appropriate?**
- **Cleanliness & Meticulousness**
- **Dealing & managing Paramedical staff**
- **One's behaviour with patients**
- **Time Management**
- **Equipment & Service quality**
- **Updating your skills**
- **Dealing with Referring Doctors and Commission Practice**
- **Advertising**
- **Charity & Eye Camps**
- **Social Exposure to enhance practice**
- **Allocate time for personal activities**

How much to charge and how much concession is appropriate?

- Never charge less when you are qualified
- Never tell the patient that you will charge less than others practitioners for the same procedure
- Do not feel shy in asking for money, it's your right
- Never say give whatever you want to give
- Try to be frugal when giving concessions
- Restrict 100% concession to referring doctors and your immediate family/relatives
- Some concession to relatives of staff
- Partial concession to other doctors
- Never return part of the money back to patients

When one plan's to start practice, try to understand the socio-economic class of your patients. Also get a feel of the overall trend, as regards consulting & other fees in the area one is planning to practice. There is often a misconception, that by charging less than your nearest competitor, one will get more patients. Infact often times the opposite is observed, wherein a practitioner charging more may attract more patients. Perhaps it may have something to do with the human psychology of attaching more value to expensive things or services.

By not taking charges during followup visit's one may lose a substantial income. If you have examined a patient, it is justified to charge for the service, even if it is a followup visit. After a reasonable post-op periods over (2-3months) one should charge for all subsequent visits.

Be uniform in charging all patients. Do not discriminate between rich & poor. Let your reception staff handle the collection of cash. This way one saves time

Be firm, but not rude when someone tries to argue about your fees. Often time's patients do not understand your expenses.

One can give a printed paper about all your charges to either OPD or patients who need surgery. This way a certain standardization and transparency will be established in your service.

Simple ideas like family check-up schemes, special disease specific check-up (egg: glaucoma, diabetes) may help in attracting more patients to your clinic.

Try to be frugal about any concession in your fees. One can assess the patient's special demand, by asking appropriate questions regarding their socio-economic status and then decide on merit of each case about granting concession. A good example is, giving concession to children from orphanages.

Ideally one should not charge fellow doctors, but here one should charge for all surgical procedures & perhaps not charge OPD fees.

Never return full or part of fees. This may create wrong impression in patients mind about quality of service and may even be used against you in the court of law if there is a complication.

Cleanliness & meticulousness

A patient often decides about you & your service by looking at the cleanliness of your clinic/hospital.

Instruct the reception staff to inform you about appointments beforehand & try to stick with the specific time schedule.

It is equally important to inform your colleagues like Anaesthetist, Assistant Surgeons in case of delays

When you fix up surgeries at specific time, always ensure that your OT trolley, patient, etc. are ready before the anaesthetist reach the OT.

Equipment & Service quality

In a speciality like ours, it is very important to possess the best equipment's that one can afford to buy. Often one may be a very good surgeon, but if he/she doesn't have proper surgical tools, one may not be able to deliver the highest quality of service.

It is equally important to properly & regularly maintain one's equipment's.

Re-investing in buying new equipment's is perhaps one of the best investments one can make. This helps differentiate your practice from others. Also remember to judiciously & ethically use each equipment, with patient's interest at heart (i.e. not advising unnecessary procedure to fulfil financial liabilities). This policy will always pay in the long run .

It is mandatory to maintain all patient records-IPD & OPD, not only for medico-legal reasons, but also for easy reference for future treatment and may also be useful for research.

Updating skills and academics

With the introduction of new law for renewal of registration, it has become mandatory to attend seminars & conferences. However this may be a wrong approach for those really interested in updating skills/knowledge.

With the advent of internet, it has become very easy to read, see a variety of academic content. What is required is to dedicate time for this from one's busy life. Those who meticulously spend time reading literature are always better in managing patients.

We are indeed lucky to have an academically oriented society like ours(Poona Ophthalmological Society), which gives us opportunity to interact with a variety of learned practitioners, by organizing regular seminars , symposia & conferences.

One should also remember, doctors actively involved in publishing in journals or participating as faculty in conferences are automatically recognized for their work by their peers. This always helps generate speciality practice (referrals from specialist of the same branch)

Dealing with Referring Doctors and Commission practice

Ophthalmology practice is majority direct practice. Depending on referrals in the initial years may help, but its importance diminishes over the years. However it is important to maintain cordial relationship with all doctors in your area, whether someone refers patients or not.

Commission practice is a controversial subject. Ideally one should not be involved in such methods, however in today's world of fierce competition, perhaps it is unavoidable. However, as mentioned earlier, majority of our practice is direct.

If the quality of work speaks for itself then one may not feel the need to follow such means.

When operating in OT's owned by GP or non-ophthalmic doctors, remember to ascertain level of asepsis, cleanliness of that hospital. In case of an unfortunate incidence of post-op infection, the owner will often disown responsibility & the operating surgeon will have to bear the brunt of blame.

Advertisements

Legally an individual practitioner cannot advertise in any public medium (like hoardings, newspaper), unless there is a very clear reason, like for example, shifting to a new place or to inform about leave of absence.

However one can take advantage of medium like internet, by having your own website.

Distributing & displaying attractive & eye catching advertising material in your premises can also help.

Remember, the importance of advertising ends as soon as a person enters your consulting room.

Charity and Eye Camps

Conducting regular eye camps in your own premises is a good way to fulfil social obligation, but may not be beneficial, financially as many of the patients coming for these camps cannot afford your services. It is however useful way to advertise about the quality of service you provide & also about its variety.

However remember rendering any service free of cost is to devalue its importance, which might backfire on you in future. It is always preferable to charge at concessional rates during the camps, instead of no charge at all.

Maintain and deliver the same quality of service that you normally do for all paying patients.

Social exposure to enhance practice

By becoming members of social organizations like Rotary or Lions, one gets to know the cream of society from a variety of spheres. This definitely helps build your reputation & hence your practice.

It is equally important to be actively involved in such activities, so as to ensure better rapport with important members of our society.

First impression sometimes decides whether someone gets operated by you or your neighbour. One can spend a lot of money on interior design, but if not well maintained this money may be a waste.

Even your reception staff should be attired in clean clothes, should be trained to maintain certain decorum when in clinic, talk softly & politely with everyone.

Be very strict with your staff regarding matters related to cleanliness.

See that all equipment's are cleaned regularly. Pay special attention to simple things like chin-rest of slit-lamps, keratometers. Ensure that all necessary stationary is available & in its proper place.

Cleanliness & asepsis in OT is of highest importance and it has to be regularly monitored.

Attention to details is of paramount importance.

Dealing and managing Para-medical staff

- Para-medical staff payments should be the same as what others in the industry pay
- Define specific roles of each staff & donot give excess freedom regarding what one does
- Constant supervision of quality of work is very important
- It is important to have excellent man-management skills to retain most efficient staff.

Every staff's role has to be well defined. This is particularly relevant for ophthalmology day care centres where untrained/semi-trained staff are employed to manage the centre (As against big hospitals, which employ trained staff)

Always be firm with your staff, particularly if they do not work according to what has being assigned to them.

Reward good quality of work. This will boost their morale

Optometrist often project themselves as doctors & even may try to over-impress on patients their importance. In such situations, have clear guidelines, monitor their (optometrist) behaviour by other staff members, tell reception staff to inform patients beforehand that a para-medic, who is not a doctor, will conduct basic examination & final decision will be that of the doctor.

Maintaining a healthy rapport with your staff is extremely important in smooth functioning of your practice.

Perhaps it is a good idea to employ two people to do the same job. This ensures that your work doesn't suffer in somebody's absence and they cannot dictate terms to you

Behaviour with patients

- Never talk rudely with patients, even in most trying circumstances
- Be patient with the patient, giving enough time for them to tell relevant history
- Donot involve yourself in any monetary transactions
- Always maintain a calm voice & demeanour, particularly when dealing with difficult patients/situations
- Try to under promise & over deliver.

Always remember that we are dealing with persons, who have all kinds of emotions, feelings and who are judging you knowingly or unknowingly. Be very polite with each & everyone. One often comes across very renowned & senior practitioners who either totally avoid taking with patients or talk very curtly. Try and maintain continuous eye contact with patient/relatives. This signals your interest in their matters and helps build trust and confidence.

Do not neglect even seemingly trivial or insignificant aspects of history; that may perhaps be the vital clue in diagnosing an illness.

Try explaining medical matters in local language, with minimum use of medical terminology & in as easy words as possible. Spend extra time with patients when discussing difficult situations. Be clear about your thought process & let this be known to the patient. Good communication skills are a very important aspect of one's practice.

When dealing with patients who have had complications/mismanaged by fellow colleagues, never criticise you colleagues in front of the patient/relatives. Be diplomatic in answering pointed questions. Perhaps it is better to talk with your colleague in private, to understand what went wrong. These patients, often agitated need simple words of reassurance and compassion. This way one can avoid ugly medico-legal problems.

One can use specially made videos or animation to explain different surgeries or procedures. However ask patients if they would like to see such films, which perhaps may not be appreciated by some.

Always try to under promise & over deliver. This helps improve confidence of patients in your services.

Time Management

Only if you value others time, will they value yours.

Since we are in a surgical speciality, time management is of special importance.

Always inform your clinic staff in case you are going to be held up in an operation or in transit. Similarly inform the staff about your leave. If possible put up notices in your clinic about your absence.

Allocate time for personal activities

We remain very busy in our profession throughout the day. It is extremely important to allocate some time for a regular exercise, leisure activities and even pursuing hobbies on regular basis. Daily 45 min to 1 hr of exercise is a must. Similarly pursuing regular hobbies like music, painting, trekking help relieve stress & keeps mind fresh.

One more important aspect is to have yearly medical check-ups from your physician friend, so as to avoid unexpected illnesses.

In summary, Medical Practice, although considered as 'business' cannot be categorized as such. It should be looked upon as a special form of service, having ethics as its backbone. If one remembers not to compromise on patient quality of care, even if there are no big financial gains, you can truly become a successful doctor.

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HOW TO SELECT APPROPRIATE TECHNOLOGY/TECHNIQUES AND INCORPORATE THEM TO ENHANCE PRACTICE

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e-mail: suhashaldipurkar@laxmieye.org

In this technology driven world in order to keep pace with the clinical practice, there is a need to keep up with the modern technology and newer techniques. Newer technology would most often help manage patients in a better and more predictive way. When it comes to diagnostic and therapeutic interventions newer technologies have changed the way we approach the patient. We have more objective measures to quantitate the signs (OCT in macular edema is an example) and are able to demonstrate to the patient the pathology and improvement or deterioration of a clinical condition.

Good old bed side medicine and the clinical medicine are making way for the technology driven and evidence based medicine.

The good side of modern medicine is that the quality of care has scaled up but the cost of practicing medicine has proportionately scaled up too.

When we talk of incorporating new technology into one's practice lets look at where we are coming from.

We as eye care professionals have to set clear goals in our professional life.

It is time for introspection and to self audit the need to adapt to newer technology. Begin with the end in mind to assess the feasibility of incorporating the new technology...

When you are adopting a new technology in your practice you need to have a thorough knowledge and experience with the basics first and know about the experience of other experienced colleagues.

It is also essential to know the risk benefit ratio of a particular procedure or technology. (Conductive keratoplasty is a glaring example)

It is also essential to know about the available resources for appropriate training to adapt to that technique and to know one's own limitations.

It is difficult to incorporate new techniques into existing practice without a clear process for doing so.

After watching new techniques at the meetings and conferences individuals will experiment with a couple of strategies, only to return to old routines when there is little follow-up time or opportunity to train and get supervised.

The application of new technology starts right from the registration process. Hospital information system (HIS) and clinical information system (CIS) are just the two of the various new technologies that are waiting to be adopted... Clinical information helps you maintain the data in a compact way. Faster retrieval of case paper saves time and man power.

Hospital information system helps to analyze the patient input and for financial planning.

E.M.R. (electronic medical record)

Electronic medical records, however difficult to set up, can actually carry with them many benefits in your practice

With EMR, not only are medical records accessible instantaneously, but they can be accessed from multiple locations. While startup costs for EMR systems can be significant, the ability to go paper-free conserves significant resources. Besides the obvious smaller items such as paper and toner cartridges, large amounts of physical space once used for storing case sheets can now be liberated to use for alternative uses.

Let's look at some guidelines to help us incorporate new technologies in to our practice.

1. Newer technology should have distinct advantage in our practice over the present technology. For example it does not make sense to buy a GDx machine in general ophthalmic practice. OCT would be a good investment for a clinic with a moderate sized OPD.
2. Newer technology should be applicable to more common diseases. (E.g. Perimetry would be a good investment in a clinic with an OPD with elderly patients.)

3. Newer technology should be cost effective. The diagnostic equipments take a longer time to recover the investment whereas surgical equipment may recover the cost faster.

The simplest new technology to adopt in anybodies practice be it small practice or a big corporation is lens based technology as far as ophthalmology is concerned.

In the recent times rich dividends have been gained by adopting this technology.

This technology is easily adoptable without much of investment. One needs to learn to use this new technology and select patients who can benefit from it.

Once you start offering this technology for the pure pleasure of offering it you start seeing lots of them taking benefit of it.

Toric lens technology is one such example. Next one is multifocal technology – this was one technology that took time to become popular. It was because the professionals were not convinced and the patient selection was not fine tuned. And now of course with trial & error technology and the techniques have improved.

Let's turn to technology that needs intense training and mentoring; phaco is one important example of a technique which all of us have to learn at all the cost come what may. And after you play your cards well and become good at it you are ready to use this technique for difficult situations.

Another significant technology that has made immense difference to the cure of blindness is corneal lamellar procedure. This new procedure is a living example of how human scientific mind and innovative urge can take you places in terms of making a visible change in the world we live.

This is an example of a technique that is difficult to learn but has rich dividends to the patients and the doctor.

As a general ophthalmologist in practice, one can adopt many new methodologies and techniques to enhance one's practice and serve our patients better.

Let's take an example of pterigium surgery. Use of glue instead of sutures has made a world of difference in surgical outcomes.

Use of releasable sutures, inj MMC intra op and injection 5 f.u. in the post op period, have all added to improve surgical results.

Use of newer molecules in Dry eye treatment & glaucoma control has worked marvels.

Such small incremental advances by way of new technological adoption are important. These small steps enhance our practice and bring in rich dividends.

In other words every one of us has to look out for newer technology and assess if this technology is adoptable in our set up and if so go ahead.

All successful practioners have done it and will continue to do it.

What will keep you in competition and against the corporate houses and big hospitals is this quick and fast adoption to newer technology and techniques.

Friends in conclusion I wish to reemphasize that the secret of those who have made it big by the conventional standards of the universe are the ones who always strived to live outside the comfort zone to achieve what they did.

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IMPACT OF OPHTHALMOLOGY CHAIN ON OPHTHALMIC PRACTICE

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The face of India is changing at a rapid pace with retail being the new buzz word. It all started possibly with Mc Donald's in the US many years ago. In the last decade India experienced a sea change with the Big Bazaars and Home towns sprouting all over the country. The healthcare sector was not to be left behind. Starting with skin and beauty care clinics, the trend of clinic chains has now percolated into dental and eye clinics and more recently dialysis centers.

Though, private practice still remains the most common pattern of medical care, the entire scenario of health care especially pertaining to ophthalmology is fast changing. Conventional private practice enjoys the advantage of complete independence and non interference as far as the clinician is concerned, but there is a price to pay for that independence: the tireless toiling involved in the setting up and establishment of a private practice, the non negotiable gestation period that consumes one's energy and youth and the special efforts needed to establish one's credentials in the community are all well known to those who have travelled this path. The well established diktat 'as you sow, so you reap' works well in private practice. The perks in terms of remuneration and earnings are more than often extremely satisfying at the end of the day. Moreover, the independence permits one to make a flexible working schedule, tailoring it to one's personal needs and pursuits beyond the realms of medicine.

Private practice is limited by financial constraints. Capital is raised by either own funds or high level of debts. The cost of medical equipment especially imported ones is quite high. The charge of services in the Indian market is quite low; hence there is significant financial constraint. Growing capital intensity due to cost of location, medical equipment and technology and growing cost of financial sources of capital investments are some unfavorable environmental factors experienced by private providers.

The institute/corporate practice provide an amalgamated environment of amateur and experienced professionals and provide a secure work atmosphere where the responsibility is always combined, so are the perks! It behaves as a good nursery for evolving professionals giving them ample opportunities to learn. The experienced can utilize the institutional cocoon to try new innovative techniques without having to face ethic committees and lawsuits all alone. The institutional umbrella protects its professionals from quite a few adversities of the profession. It is not so in private practice where one has to stand up for oneself. The practice runs on the name of the doctor and heavily depends on the manners and approach of the doctor and his staff. In addition the patient demands more from an individual practitioner not only for time and care but also results. The doctor has to consistently deliver good results. A private practice automatically means zero tolerance for mediocre results. In addition the doctor also has to manage the administrative aspects of the practice. Our professional training programs lack this aspect of practice management entirely. Affording staff also is an issue – many a times a practice manager may not be available to take care of the day to day needs of the practice. Also, the running costs of the practice have to be borne. Investing in newer and latest technology is not easy as there are financial issues and obstacles. The eternal dilemma of not compromising on quality and sticking to the budget becomes important. While one may not cut corners in this practice,

there is a possibility that one has to make do with the basic equipment one has. In corporate chains or institutes, the doctor does not have to worry about the administrative aspects or staff issues and there is ample scope for investment and getting new technology.

While the doctor may perceive intimacy as a burden, the patient paradoxically, seeks it the most. To “patients,” quality means being seen and heard as a person. It's when a doctor sits down and listens to their complaints, and has time to examine them that they feel satisfied - this is the core philosophy of private practice. In a clinic chain or institute, the patient is one of many and continuity of care with the same doctor does not happen many a times as doctors' work in shifts. The assumption that a large health care organization or a corporate chain ensures a “higher quality” of care is not always true. Intimacy of longstanding doctor-patient relationships” disappears. In institutional settings, “people” become “patients,” waiting long hours to see their doctors and, when finally seen, are examined by physicians who barely know their names. These physicians work for fixed salaries and lack in motivation to excel or provide the best care for the patient as their salary is going to be delivered irrespective of their efforts. Institutes argue that this makes the entire health care delivery more professional, with protocol based management and uniformity in health care, but whether the patient prefers a “human” doctor or “robotic” doctor is again a matter of debate. Often, corporate hospitals act as assembly lines and become too commercial. In many organizations, incentives are given. The incentives given are not based on the surgical skills or patient care but are based on the money generating capacity of the doctor – this leads to unnecessary commercialization of health care, the patient is burdened with unnecessary tests for instance a patient with astigmatism is made to undergo an expensive orb scan. Patients with vision 6/9 with hardly any cataract are convinced to undergo cataract surgery. The basic ethos on which medicine is based, that is on ethical and honest patient care is violated.

More importantly a well trained surgeon, in a corporate, finds himself at the mercy of the organization. He becomes a money generating commodity who is expected to follow the rules laid by the MBA trained administrators who, in turn, tend to set unrealistic targets and monetary goals. They fail to see the human angle in this and treat it solely as a business enterprise designed to generate profit. There have been many instances when surgeons have given up their practice or merged it with that of corporate chains only to be unceremoniously thrown out by the corporate losing their practice, job and self respect. The talent and intelligence may not be of any concern for the corporate chains as they have purely commercial interests and patient care is not the priority. In addition there is no guarantee that at the end of a decade of service for the corporate organization, you will have any value or say in the organization, leave alone the guarantee that you will stay on. The emotional trauma of being disowned was recently witnessed by a very competent eye surgeon who worked for the leading eye care provider in the country for a decade and spared no efforts in creating a name for the organization. When he wanted to be a part of the chain in his hometown he was shown the door. Job security and stability is extremely questionable in these organizations. When there is a needy patient, the doctor working in a corporate may not be in a position to help the patient by giving discounts which is possible in a solo or small practice. As there are many overheads that tag along with a corporate, the overall cost of health care shoots up.

Corporate clinic chains will be an integral part of health care and with more specialties including cardiology centers now coming into their realm, it remains to be seen how the face of health care in India is going to shape up in the future. It is interesting to note that in spite of supermarket chains coming up – the neighborhood grocer still holds his forte even in major cities in the country – the same will possibly hold true with private practice.

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ELECTRONIC MEDICAL RECORD- IS IT NECESSARY?

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Very few Practices (Ophthalmology) in the country have adopted any kind of EMR for data storage. In general, recording of patient data, in any form, itself is not given importance it deserves. We are obliged by law to maintain patient data, for a specified period of time, which maybe necessary for medico-legal & clinical purposes.

Electronic Medical Record systems have being in vogue for quite sometime. However there has been very less enthusiasm amongst practitioners to adopt them.

An EMR software ideally suited for use & at the same time being cost effective is a distant dream.

Let's look at some advantages of EMR

Quick Access to Information: When reviewing patient data, getting access to previous information, relevant to the patient, is always helpful in better patient care. Recording information on papers has its shortcomings. Paper need large storage space. They can be destroyed. Loss of case sheets is a common occurrence. All the above mentioned disadvantages are negated by EMR.

Volume of data: Over a period of time each case sheet has tremendous volume of data generated. It becomes important to record each finding during each examination. An EMR can easily collate all this data, in a concise manner, which makes data review easy & fast.

Recording data at multiple locations: Given the ambulatory nature of ophthalmology practice, having access to data at multiple locations becomes important. It is common to have practitioners rendering services at many clinics/hospitals. Patients also tend to be mobile. Having access to patient data at remote location obviously is advantageous.

Collecting data from variety of diagnostic equipment's: Often times one has to order variety of diagnostic tests. Most of equipment's used in ophthalmology practices operate digitally. Hence it becomes very easy to collect all information at a single user interface, for better analysis.

Communication: With the advent of electronic communication, it is very easy to send & receive information instantly to colleagues. There is no constraint on the volume of data to be communicated.

We now have also to look at some of the major disadvantages of EMR's

Cost: This remains a major hurdle in using EMR's. The project cost includes, the Hardware, Software and also cost of training staff. Having invested so much in setting of EMR, it cannot generate revenues directly/indirectly for your practice.

Time consuming: Most of us use computers routinely. But few amongst us can boast of fast & efficient typing. This remains a major bugbear in recording data. It is still fast to write on paper than to type oncomputers. Although using the software is easy, time taken for data entry slows things down. Often our attention maybe more towards the computer screen than talking with patients, which can be interpreted wrongly by the patient. Learning to use the software or even computers can be a problem for ancillary staff. Time consumed for entering data, can also reduce efficiency and disturb time schedules.

Maintenance & upgrades: Often times the vendors, who sell such products, may not have trained personnel to provide maintenance for the product. Upgrades made in due course of time maybe charged for, often at unreasonable rates.

Having gone through some of the key aspects of EMR, I would like to share my personal experience of using such a product for last 1 year.

The main reason to buy this product for our practice was, large storage space required for paper, access to data at multiple clinics, access to variety of data at a single interface. Also it is much easy to review your data, in a variety of ways.

All these needs were satisfied by the software, however there are some shortcomings. The main one was in a single doctor practice like ours we have to do all the work i.e. from clinical tests to data entry & finally giving a prescription. The faster one does this the better the efficiency & productivity. Using an EMR definitely slows the workflow to a large extent. Also one has tobe vigilant about data loss, because of hardware glitches. Hence a regular data backup is very important. It becomes difficult to employ a trained person for maintaining this systemin a solo practice.

What's in the future? With increasing awareness amongst our fraternity, we will have more user friendly products at perhaps cheaper rates in future. There are products in the market, which directly record from paper to computers. These devices should be integrated with the software, which will improve data entry speeds. Cloud computing will help in continuous data storage, thereby reducing chances of data loss.

Going paperless is not possible in our profession, but reducing its use is definitely possible and beneficial. We hope to have EMR's which will help improve our efficiency & quality of service & record data in a far more flexible and retrievable manner.

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FINANCIAL PLANNING FOR OPHTHALMOLOGISTS

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The role of ophthalmologists in India is expanding beyond the traditional role as a clinician. Ophthalmologists are currently expected to perform effectively as leaders, visionaries, managers and social and business entrepreneurs in addition to providing clinical care. One such challenging managerial skill is the financial planning and management. Financial management is not limited to accounting records. It is an important part in hospital management and must not be seen as a separate activity left to finance staff. The need for Finance evolves even before the commencement of any concern.

Finance is required for meeting not only the capital investments needs but also the working capital needs. which have to be mobilized through various sources such as Individual share capital, Term Loans from Banks or Loans from other resources. Normally loans are secured by mortgage or hypothecation of physical assets carrying a fixed rate of interest and are repayable in installments according to a pre-determined schedule. For beginners and those who do not have own source of funds and adequate assets public financial institutions are not of much help. However if the ophthalmologists can demonstrate use of novel technology or good business model, venture capitalist, who normally provide funding to early-stage, high-potential, growth startup organizations, will be interested to finance. The venture capitalist make money by owning equity in the organization it invest in. Venture capital is attractive for new organization with limited operating history that are too small to raise capital in the public markets and have not reached the point where they are able to secure a bank loan or complete a debt offering.

The proposed investment maybe for starting a new eye hospital or expanding the existing facility with additional speciality services such as retina, glaucoma, paediatric ophthalmology, etc or planning to invest on an equipment of high capital cost. Whatever maybe the investment for, the project should demonstrate feasibility and profitability to enable bankers or a venture capitalist to fund the project. When an eye hospital is able to project the need for eye care services through magnitude of blindness in the service area, predict the number of people and the price they might pay for the services will justify if the project is feasible. To know if the proposed project is profitable the project should be able to predict a high returns on Investment.

Return On Investment (ROI) analysis compare investment returns and costs by constructing a ratio, or percentage. In most ROI methods, an ROI ratio greater than 0.00 (or a percentage greater than 0%) means the investment returns more than its cost. When funding is limited only for starting one particular sub specialty (eg. Retina or paediatric) or purchasing one major equipment (eg. excimer laser or OCT, FFA, etc) among various choices, the investment which yield higher ROI is considered the better choice, or the better business decision. A simple return on investment is arrived at,

ROI = (Gain from Investment - Cost of Investment) ÷ Cost of Investment × 100

For example consider two five-year investments requires funding, Plan A and Plan B. In order to calculate ROI, we need to see both cash inflows and outflows for each year as well as the net cash flow. The tables below show these figures for each investment, including also cumulative cash flow and Simple ROI for the investment at the end of each year.

Plan A	Now	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Cash Inflow	0	5,00,000	6,50,000	8,50,000	10,50,000	12,50,000	43,00,000
Cash outflow	10,00,000	3,00,000	3,50,000	4,50,000	3,00,000	2,50,000	26,50,000
Net cash flow	-10,00,000	2,00,000	3,00,000	4,00,000	7,50,000	10,00,000	16,50,000
Cumulative cash flow	-10,00,000	-8,00,000	-5,00,000	-1,00,000	6,50,000	16,50,000	
ROI	-100%	-61.54%	-30.30%	-4.76%	27.08%	62.26%	

Plan B	Now	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Cash Inflow	0	10,50,000	9,50,000	7,50,000	4,50,000	5,00,000	37,00,000
Cash outflow	10,00,000	3,50,000	3,50,000	3,50,000	2,00,000	2,00,000	24,50,000
Net cash flow	-10,00,000	7,00,000	6,00,000	4,00,000	2,50,000	3,00,000	12,50,000
Cumulative cash flow	-10,00,000	-3,00,000	3,00,000	7,00,000	9,50,000	12,50,000	
ROI	-100%	-22.22%	17.65%	34.15%	42.22%	51.02%	

In the above example though plan A gives more return at the end of 5 years, however plan B is a better investment option as the payback period is 1.5 years and the return on investment is positive from the end of 2nd year.

While calculating return on investment, the concept of “time value for money” should be considered too. This concept is based on the fact that the value of money diminishes with time. So in order to arrive at the actual gain on investment figures, a pre decided percentage should be subtracted from the total cash flows. This is called the Net Present Value (NPV) technique. When Ophthalmologists make use of these tools for their investment and write up a good business plan, they have higher chances of having funding support from various sources.

Income and expenditure is one of the key component in arriving at the ROI. When we talk about cash inflow and outflow in the above example it specifies the income earned and expenses incurred from our investment. Our strategy must be to maximize income and contain cost to be sustainable and profitable in the business. Private ophthalmologist have a wrong misconception that people perceive high charge as high quality and thereby attract only the high income group and perform less number of surgery. As the problem of blindness is common across all groups of people irrespective of their economic status, private ophthalmologist should have different pricing for different group of population without compromising on quality of care. The variation in pricing must be based only on the comfort provided to patient. This will help them to increase their productivity which results in increased income and reduce the cost of services. If the productivity increases, the unit cost will come down as in any ophthalmic practice it is the fixed cost such as salary, building rent, maintenance, etc constitute a major portion of the cost. The variable cost such as medicine, etc is relatively less and in most private practice, patients are asked to buy them directly. At the same time one should be cautious that operating more number of patients beyond the capacity of ophthalmologist or operating room could bring down the quality. To be more productive private ophthalmologists should aim to operate daily so that they can even the number of surgeries based on their capacity limit instead of operating on more patients one day and less the other day.

The practice of ophthalmology is increasingly becoming sophisticated and new technologies are introduced every year. The patient is also demanding the latest technology, which is always equated with better outcome. The investment costs are high and so is the need to invest time to update oneself constantly. The single practitioner is disadvantaged both from the investment front and from being able to take time away for training.

Group practice would allow this to a greater extent and also ensure better utilization of the investment. If 4-5 ophthalmologist belonging to same area can setup a common diagnostic facility, the cost of investment can be shared rather than duplicating 4 or 5 times. This can help in reducing the cost to patient and thereby directly compete with the institutional practice. Similar approach can be made on the group purchase of consumables to get maximum discount from the supplier.

Monitoring finances is not just the income and expenses or the profit/loss as it may not give a clear picture of the growth of the hospital. We should interpret the financial statements to understand the financial implications for efficient decision making. If necessary we must modify the financial reports which would give meaningful information. Some basic information that could be looked into from the financial statements are

- Comparing Current years financial results with previous years. This will help one to know the growth trend and progress of the hospital services.
- Vertical and Horizontal analysis of income and expenses - eg. % of income from outpatient charges against the total income, % of staff salary against the total expenses. This will help to understand the major contributing income or expenses and when compared with previous year, we can know the variation percentage and identify any problems within the system
- Cost recovery in percentage - calculated as (Income / Expenditure) x 100 . This ratio helps us to know if the organisation is able to meet the recurring cost (fixed cost + variable cost) from its income. If the cost recovery percentage is 100% then the organisation is breaking even and if less than 100% then the organisation is making loss and will be facing problem to meet its recurring cost such as salary, etc. A profitable organisation should have a cost recovery percentage more than 100%. Cost recovery can be calculated based on total income or excluding income from other sources so that we can know the cost recovery based on patient care services which is the backbone of any ophthalmic facility.

One cannot keep on increasing the price of services to meet his cost. This will result in dissatisfaction and reduce the demand for services. Hence the emphasis has to be placed on control of expenditures so that financial commitments can be met.

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RESEARCH IN PRIVATE PRACTICE

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Research! Most consider it as an entity separate as against practice of medicine. But, this might not be entirely true. I believe every clinician in private practice keeps doing research, every day! However, unfortunately not many are able to apply sound epidemiological principles and/or biostatistics to their research. An ophthalmologist whether in private, public or in an institutional practice needs to conduct research simply because practice of ophthalmology requires a good balance of everything; science, arts and commerce!! Maintaining a balance of all the components in a practice is professionally satisfying and may result in a better ophthalmologist and better ophthalmology.

It makes sense for private practitioners to do research because that is the way to share the experience and outcomes, improve the practice patterns and stay in touch with the latest trends. Of course there exists a different breed of ophthalmologists who are primarily researchers and the ophthalmologists of this species are found in abundance in an academic institution that is primarily research driven. In countries like USA they pursue a different course, namely, MDPhD and now in India, institutions like LVPEI and SN have a different research fellowship a propos clinical fellowship.

Nevertheless, despite of maintaining a busy schedule, a private practitioner can certainly pursue clinical research. I am here to share my knowledge about how to do clinical research while one continues to have a moderate or a roaring private practice!

Make up your mind and commence the journey!

Once we are convinced to include research as part of our daily practice and not something that will be done in a dedicated laboratory, buy these books.

1. Clinical Epidemiology: How to Do Clinical Practice Research. 3rd edition by R. Brian Haynes , David L. Sackett, Gordon H. Guyatt , Peter Tugwell, Publisher: Lippincott Williams & Wilkins.

2. Studying a Study and Testing a Test: How to Read the Medical Evidence. 5th edition by Richard K. Riegelman. Publisher: Lippincott Williams & Wilkins.

3. Statistical Research Methods in the Life Sciences. P. V. Rao Publisher: Duxbury. Free email download (http://ebookee.org/-request_ebook-Statistical-Research-Methods-in-the-Life-Sciences_159414.html)

However, it will be a lot easier, if one attends a CME or a workshop on research methodologies (Table 1). These programs usually reduce the phobia and boredom that is often experienced by a beginner. A workshop usually provides relevant reading material and more importantly it gives a teacher who would guide you through. I believe, books can only provide information but a teacher can translate it into knowledge until it is ingrained as scientific wisdom with due efforts of the student. The teacher will make sure we never give up especially when our motivation is down.

One problem that an ophthalmologist in private practice would face is inability to access full text of the articles relevant to the research. If online free full text is not available and the information in the abstract is not enough, write to the corresponding author or the co-authors. Their email ids frequently accompany their articles' abstracts in the pubmed or one can find them on google or any other search engine or the website of their institutions. I have found most of them kind and many oblige by sending a soft copy as an email attachment.

Alternatively register free with centaur pharma website -

(http://www.centaurpharma.com/registration/login.php?login=1) or login to ONE network (http://aios.org/) for a free access to many prestigious journals. In case of articles published >10 years back, or in-availability from above sources, place a request to the National medical library, Delhi

(http://www.nml.nic.in/services.html) or your acquaintances in the leading institutions like LVPEI / SN / RP center. If you do not have one, email to the faculty of the relevant department who works in those institutions. Few of them have time and are generous (repetition of word kind with some context) enough to help you with the full text. One can also take help of the Indian Journal of Ophthalmology or faculties of the foreign institutions/libraries.

Next issue is of registration of the trial with clinical trial registry of India (CTRI) and a clearance from the institutional ethics committee (IEC). If an observational study is done without registration with CTRI or review by an IEC, it would not be unethical provided current preferred practice protocols (PPP) are followed. However, to safe guard patient's interests, during a randomized controlled trial or when the PPP is not followed, approval from an external IEC will be necessary. The details about the external IEC in the respective geographical area would be provided from the directorate general of CTRI upon registration of the trial with the CTRI.

For retrospective studies, past medical records are necessary. Many practitioners give away the records to the patients leaving them absolutely without the data. In urban areas preserving the medical records of large number of patients for long periods may not be feasible due to space constraints. It is imperative in such situations to invest into one of the ready-made but modifiable, electronic medical record (EMR) system/software. Custom made softwares are too expensive and takes lot of time to develop. There are many ready to use programs that are user friendly and provide complete hospital management solutions. They usually cost anything between 25,00.00'-40,000.00 '. A software from visual info soft private limited works well and their after sales service.

isexcellent

(http://121.246.81.79/VIPL1/GenInfo.aspx).*We have no commercial interests in their product.*

Consent for research in private practice is a tricky issue. Many patients are from higher economic strata and professionals who do not have time to come back repeatedly for the follow ups. However, at the same time they are well educated and if a clinician is convinced about the need to perform the study, it is not very difficult to explain to them and include them in the research. A clear explanation of the study is necessary. However, it may not be wise to give them an incentive to participate in the study. They are super convinced if they know that the results of the study would benefit them personally by improving their medical management.

Another problem that a consultant in private practice would face is adherence to the standard operating procedure (SOP) for an extended period of time. This is especially difficult when the consultant visits a number of locations in the city/country. In such situations, training sessions and repeated review of SOPs will be necessary to make sure that same SOP is followed at all the locations. It makes the study more difficult to administer but at the same time, it brings in a unique opportunity to investigate the effects of different population type or geographic locations on the question under investigation.

Analysis of results in an appropriate manner using biostatistics is considered complicated. However, for a beginner, an easy way is to look up the relevant published literature and find out what statistical methods were used in those studies and simply reciprocate if the study design matches. If that does not suffice, one can refer to the articles on sample size calculation, tests of significance, confidence intervals, measure of dispersion etc. or simply look up the text books that I have mentioned above. It is good to take help of a teacher after the researcher has decided what bio-statistical method would be ideal for the analysis.

For the calculation of the statistical parameters, I suggest use of Microsoft excel program simply because it is easy, available to all and sufficient in most situations It also generates graphs. However, if one needs more complex statistical analyses, use *Analysis ToolPak.*

You provide the data and parameters for each analysis, and the tool uses the appropriate statistical or engineering macro functions to calculate and

display the results in an output table. Some tools generate charts in addition to output tables. To access these tools, click Data Analysis in the Analysis group on the Data tab. If the Data Analysis command is not available, you need to load the Analysis ToolPak add-in program (for free!).

For multivariate analysis I suggest NCSS (Number cruncher statistical software) the demo version can be downloaded from
http://www.ncss.com/download_freetrial.html

There are many cool online statistical calculators to assess various parameters such as power of the study, confidence limits, assign subjects to groups, get p values etc. I prefer

http://www.graphpad.com/quickcalcs/index.cfm

Although, Microsoft excel is very user friendly, I suggest beginners to use it with the guidance of someone who is already using it.

Once the analysis is done, it is not difficult to pen down the study and interpret the results in wake of the previously published literature. For beginners, Practical suggestions in the writing of a research paper by Biwas J would be very useful.

Fortunately, all the journals at present accept the articles for review online and the practitioner is free to submit the article to a journal in which he/she would expect to get the relevant audience.

By no means, performing research is a day's job. For me, it takes nearly one to one and a half year to conceive a study and get published in a refereed journal. However, the joy of seeing one's study published in a peer reviewed journal is beyond words. The professional satisfaction gained out of publishing a study that has potential to improve the patient care is immense!

I believe the contributions made by the private practitioners who are already giving wonderful treatment to a fortunate few who attend their offices can be multiplied if they contribute to the research in ophthalmology.

Acknowledgements:

Prof. Dr Ravi Thomas: An ardent teacher and avid researcher whose teachings have created a scientist in me. I cannot thank him in words. I pray that every student gets a teacher like him.

Table 1: Recommended courses on research methodologies for the beginners.

Name of the Course	Duration	Websites
Principles and Practice of Epidemiology	10 days	http://home.cmcvellore.ac.in
The research methodology workshop	2 days	http://www.ijo.in
Training course in Epidemiology and Research Methodology for Senior Health Managers	6 days	http://www.kem.edu/college.htm
JIPMER Basic Epidemiology Course	5 and a half days	http://www.jipmer.edu

* * *

GET PAID FOR YOUR CHARITY

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11th five year plan aims at making National Program for Control of Blindness address issues leading to Blindness in a comprehensive manner like management of Diabetic Retinopathy, Glaucoma, Squint, Keratoplasty, Retinopathy of Prematurity, Low vision etc. in addition to Cataract, Refractive Errors and other ongoing schemes of 10th five year plan.

The National Program for Control of Blindness (NPCB) has been able to deliver effective and efficient eye care services through successful Public Private Partnership (PPP).

All of us usually do community work at least at the start of our practice for some years. Usually this is done to increase the number of patients and thereby creat awareness of our practice in community. However wefail to keep record of our patients. If we keep record, it will be beneficial for us in many ways. If we startmaintaining records of all the patients we see anyone can participate in the programmes of NPCB. Only requirement is, you should be a part of charitable association as Individual Practitioner is not eligible for receiving grants or donations.

Starting NGO

You can start your own NGO by taking some likeminded people or some of your family members, who share the same interest. One needs to register the NGO with Charity Commissioner. There is a minimum requirement is 5, 7 or 11 people to start with. A constitution has to be framed outlining the aims & objectives of the NGO. A President, Secretary, and Treasurerneeds to be appointed to run the NGO.

Your NGO's name has to be unique, one which no other NGO owns.

Memorandum of Association include:

- Name of your Association,
- Address: It can be your clinic or residential address.
- Objects of the Society: In this you can include, to conduct various health related programs like camps, to conduct various national programs like Blindness Control, etc.
- Members of first Governing Council with their designation like President, Secretary, Treasurer etc.

Rules & Regulations of the Association : Generally theses are uniform & almost same for all the Association. If you want, you can add or delete some points from it.

Once you submit your application with charity commissioner, your NGO gets registered usually within 6 months & you get certificate of it.

What Next?

If you have your own set up with Operation theater, get it certified from District Ophthalmic Surgeon & Civil Surgeon.

Schemes for Voluntary Organizations:

The purpose of the Schemes is to develop eye care infrastructure and to provide appropriate eye care services to reduce the prevalence of Blindness. Following schemes are presently available for the Voluntary Sector:

A. Recurring Grant-in-aid

For free cataract operations and other eye diseases in camps.

For eye banks for collection of eyes of Eye donation.

B. Non-recurring-grant-in-aid

For strengthening/expansion of Eye care units to NGOs. (Upto maximum 30 lakhs)

For Eye Banks. (Upto maximum 15 lakhs)

General Eligibility Conditions:

For the purpose of all the above schemes, the Voluntary Organisation / NGO will mean;

1. A society or a charitable public trustregistered under the Indian Societies Registration Act, 1860. (Details already discussed above).
2. Track record of having experience in providing health services preferably eye care services over a minimum period of 3 years. (Record keeping of all community work from the start of practice is beneficial in this case.)
3. Services open to all without distinction of caste, creed, religion or language.
4. Private practitioner M.S./D.O. with 2 year of work experience in Ophthalmology and not working with government on regular/ full time basis.

If you form NGO of your own & register it with District Blindness Control Society, your NGO will become eligible for recurring & non recurring grant-in-aid.

Your NGO should have separate PAN number so that you can apply for 80G registration in Income tax office. By this your NGO can get donations which will have exemption from income tax.

We have a obligation to society, for delivering comprehensive quality services. By forming a NGO we can do this in an organized way. Although we will need not earn a substantial income through this venture, the goodwill generated will definitely help in building a good reputation for your centre in the long run.

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INVESTMENT AND FINANCIAL PLANNING FOR YOU AND ME

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Financial Planning for Surgeons

Introduction: Have you ever had the feeling: 'Where has all the money gone? It disappears in no time if left alone . We work to earn money for a decent living.We have worked hard through our life to acquire the knowledge and skills for it. This hard earned money enables us to buy other services and goods for the present and our future. This money must therefore be respected, used judiciously and not squandered. Sadly many of our professional colleagues come to realise quite late in life having made wrong choices with tax planning, loans, investments and insurance.

Financial planning is a process of using our financial resources by setting clear financial objectives consistent with our professional and personal goals. It involves assessing what we have at present and how much we need for the future. Financial planning is not by choice, but is a necessity if one has to grow in the profession to the fullest potential, fearlessly and without any feeling of instability. This is done by assessing our assets, resources, determine our future needs and prepare for the unexpected sudden requirements.

Financial stability comes through wealth creation in small but planned increments. It comes from developing assets, saving and investing money in different forms that grows over time. These are called the asset classes. Property, gold, art collections, cash in bank, investing in stocks etc are different asset classes each of which has its own growth potential and risks. Understanding these is financial literacy.

Before we proceed to discuss further, it is useful to understand the fundamental difference between Asset and Liability. An Asset is anything that gives you money(returns),and Liability is anything that takes away your money(does not give returns, but in fact we have to put money into it). Take an example of A Car. Most consider it to be an asset. But it is not, because we have to spend money in it-maintainace,repair,fuel consumption etc. It becomes an asset only if it gives you returns that makes it profitable.

I must reiterate that while many of us discuss various tangible assets stated here, probably an easily forgotten and most valuable asset class, the intangible asset, is our knowledge and skills that we must always keep updated. At least 10% of our income must go towards this to ensure the highest 'returns'.

As Ophthalmic surgeons, we go through different phases in our professional career each of which has its own objectives, responsibilities and risks. With time and age, while we mature and get experienced intellectually, our ability to work long hours and perform complex interventions is diminished. Income may reduce over time but financial demands remain. Our responsibilities change over time. Unlike the developed industrialised nations, we do not have 'Social Security' and 'Income Protection Insurance Plans'. How can we guarantee that we can fulfil our obligations towards those who depend on us? Therefore Practice Management is integral to financial planning for a surgeon.

Economic life cycle of a Doctor: This can be broadly classified into 3 phases

1. Startup phase (Age=26-35 yrs) One must focus on savings right from this phase of life. One should be able to save at least 10% of one's income in instruments like cash, debt, equity & gold. The targeted saving of 10% should be increased by at least 10-15% each year. Started early, the miracle of compounding provides financial stability very early. Liabilities grow over time as we procure business property,equipment, house, car, etc. If both husband & wife are practicing doctors, income may be compromised from loss of working days while being away on maternity leave. And child care is not cheap and is almost the same as any adult! Allocating funds to develop corpus for children's education and their marriage, supporting parents, buying residential property do not require large contributions if started early.
2. Peak earning phase (Age=36-55 yrs) As income goes up so do the expenses. Continuous re-investment in one's practice may be required. It is a good idea to team up with like minded colleagues, who can share the risks and participate in the growth of the practice delivering quality care to our patients.This is the time to invest to beat inflation and ensure security by having contingency funds. It is important to remember to control unjustified expenses. Living within ones means is the key to building vital resources.
3. Pre-retirement and retirement phase (Age=56- 65 yrs, or till one continues to work). This should be the

best phase of ones life, if one has planned meticulously in the earlier two phases. One should be able to work not because you have to but because you want to. One tends to slow down, preferring to spend more time with family, friends or pursuing recreational activities and hobbies. By the age of 55- 60 years, for most, children are largely independent and ready to venture out on their own or even join practice. During this phase ones income may remain at the same level or infact may even reduce, but expenses surely go in the opposite direction. It is advisable not to add any new debt or liability at this point in time. One should aim to be 100% debt free.As a general rule of thumb, 70% of our peak annual earning is required after retirement.

The fact is, while we are all aware of these stages, we often choose to keep it aside until it is too late to make amends. Financial planning must be done right at the beginning of professional carrier.

Key aspects of Financial planning: Goal setting is the first step in financial planning. It is preferable to write down these goals & revise them from time to time, to suit change in circumstances. It is beneficial to have specific & precise goals regarding specific issues involved in financial planning.

Broadly speaking for medical professionals these goals can be divided in two types.

1. Professional goals and Practice development
2. Personal goals

Typically both these goals go hand in hand.These goals should be viewed with three distinctive perspectives. These are: Short term(0-3yrs), Medium term(3-6yrs) and Long term(6 yrs and beyond).

Financial planning involves the following:

- Cash / income flow & debt (loan) management
- Risk management & insurance planning
- Taxation planning
- Asset allocation & Investment planning
- Retirement planning
- Education and training
- Making 'will'

Six (Basic) layers of Financial planning.

Each layer is separate and the layers have been prioritised. Every Rupee earned must be passed from the top and then reach the last layer.

1. **Emergency Fund-** One should always have 3-6 months of monthly outgoings kept asideand invested in safe & liquid instruments like Debt & or Liquid mutual funds, Gold, Fixed Deposits(FD). It is a fund that should be kept aside and 'forgotten' to be taken out ONLY IN EMERGENCY.
2. **Insurance-** Following are the types of Insurance mandatory

- Life Insuarance for self & family- Life insurance is meant to provide guaranteed income for those loved ones who have been left behind. As a general rule,it should be ten times the annual income. It is important to distinguish between Investment and Insurance. One must shop for pure term insurance products and not ULIP's or Endowment policies. By keeping these two (Insurance &Investment) separate, one gets more life cover at much lesser premium. The charges in the ULIPs are very high and the corpus available for investment is too small to be of any significant value at a later stage. Agents, Bank Relationship Managers mis-sell ULIP or similar products because of the hefty commission they receive.
- Medical Insurance for self & family. With rising cost of healthcare, it is of utmost importance to have Medical Insurance right from the beginning of ones professional carrier. With private companies entering this field, one can bargain for variety of these products.
- Home, Building & Appliances (Home) Comprehensive Insurance. This will cover calamities like earthquake, fire, floods, etc or even theft
- Vehicle Insurance
- Professional Indemnity Insurance.
- Insurance for Business: includes Building & Equipment comprehensive insurance and Patient Indemnity insurance. For surgical speciality like Ophthalmology perhaps it would be wise to have indemnity policy of at least Rs.15-20 Lakh.

3. **Pension:** As a general rule ones pension fund should have half of current outgoings plus inflationary component at a conservative rate of 6%. If one starts investing in a dedicated pension fund at very early phase of life, one gets enough time to build a substantial corpus and with small investment. By investing

over long term, 'magic of compounding' works to ones advantage. Instruments like PPF, NSC(if re-invested), National Pension Scheme are some of the instruments in which can safely invest.

4. **Investments:** This is the corpus that one develops that should make one financially independent i.e. the return from the developed corpus should be able to generate money enough to substitute your professional income at a specific point in career. Properly planned and started early, it is not as difficult to achieve as many think. Younger a person is, greater the risk one can take enabling better returns. The proportion of investments into debt funds and those from high return funds must be carefully adjusted based on individual circumstances. Developing a well-diversified and balanced portfolio assures success. Avenues of investments are classified into three risk categories: safe, moderate & high risk instruments. In general, safer the instrument, poorer the returns. Bank/ Company FD, Government Bonds & Securities and various post-office schemes are debt funds with low, but guaranteed returns. In the current days often some of these instruments cannot keep pace with the inflation. Moderate risks instruments are Mutual Funds and equities if invested & managed well over medium to long term.

High risks are Equities on a ultra-short or short term basis.

Real Estate: It's a separate class of investment. It has a lot of variables. It needs lump sum investment on a long term basis. It locks major chunk of ones funds and it is not easy to buy, maintain or sell. It has very low immediate liquidity. However if real estate is in a developing area, one can hope for good returns by leasing or selling over long term. Remember ones clinic or hospital cannot be counted as real estate investment, but is an asset.

5. **Special Funds:** These are funds for child's education, marriage, etc. Equity diversified Mutual Long term investments in funds with good track records enable developing the appropriate corpus. Some fund houses or companies have specially tailored products for such needs.
6. **Savings:** This may shock many! 'Savings' come only when the aforementioned layers of financial planning are completed. It is the residual amount that one can keep aside for anything other than the ones stated above. This can include almost anything including leisure and personal spending over and above what is 'essential'. These are 'want based' and flexible.

Certain rule of thumb are:

- Rule for asset allocation- 100 minus your age, that percentage should be invested directly or through Mutual funds(Amount to be invested in stock market)
- 5-10% should be in gold either physical (pure gold and not jwellary) or through Exchange Traded Funds (ETF).
- Remaining amount should be invested in safe instruments.

Quick Calculators:

- Rule of 72. This is a quick rule to calculate time taken to double ones money. Eg: If rate of return is 18% then ones money will double in 4 years. 72/18. Similarly if ones money has doubled in 6 years the rate is 12%. 72/6.
- Rule of 115. This is a quick rule to calculate how much will it take to triple ones money.

  115/rate of return or number of years.

This article only outlines some key concepts useful for planning our finances for now and the future. The reader is advised to access more information about this vital topic by reading relevant articles and magazines. Please remember that depending solely on the advice of your Chartered Accountant or Financial professionals may not ensure a sound financial future. If you invest your time into it,you can expect to get reasonably good returns over long term.

A word of Caution before I end –dependable and good financial advise is hard to get. It is best to stay away from all kinds of 'agents'(various institutional advisers, relationship managers, etc). Keep your eyes and ears open to gather information but do not part with a single rupee unless well understood, carefully evaluated and analysed in line with your financial plan. This will help you to avoid 'impulsive investments'.

So far as finances are concerned trust yourself and no one else !

Summary: Goals should be realistic, and well defined. Fiscal discipline and financial prudence will enable you to achieve your goals. Plan and start investing early, regularly and systematically. These simple principles should ensure financial stability & freedom.

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www.valueresearchonline.com, www.equitymaster.com
'Lets talk Money'; Programme aired on NDTV News Channel.

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MMC Credit Hours –
Need for renewal of MMC Registration of Medical Degrees for Doctors

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Medical Practioners have being practicing for very many years with whatever knowledge they learnt during their undergraduate or postgraduate course.

There was no compulsion about updating ones knowledge and skills. Few doctors used to gain it from various Conferences, CMEs, Workshops, Seminars or more commonly from the medical representatives. With the rapid developments taking place in all braches of medicine, it was felt that if doctorsdo not update themselves on a regular basis, then they are denying the most appropriate treatment to their patients.

Considering this issue of utmost importance and with the aim of maintaining uniform standard of care, government in consultation with statutory bodies like MCI, state medical councils(MMC) decided to introduce the scheme for Medical license renewal based on certain number of credit hours accrued . Such systems already exist in many developed nations.

Important Highlights of this scheme are

1) 30 MMC Credit Hours are needed for renewal after every 5 years. One has to earn 6 MMC Credit Hours per year & not 30 points in 1 or 2 years. MMC expects 12 Hours to be obtained till Feb 2012.i. e. upto the date of registration by MMC (Please note that the first notification issued by MMC was in March 2010). If the Credit Points are not gained, one can get extension for 4 months by paying penalty of Rs. 400 but there is no excuse in earning credit hours.

2) Any MBBS or MBBS + MS/MD/PG Diploma doctor can attend CME of any general or specialized branch program of medicine and can gain Credit Hours needed for MMC registration renewal.

3) Attendance is compulsory.

4) MMC Observers may attend the Program unknowingly.

5) Filling of feedback form by the members is compulsory.

6) Certificate will be signed by CME Organizers along with MMC Officials.

7) Original MCI guidelines expect at least 1 point from Medico Legal update (which was not mentioned in MMC guidelines). Now it says- CMEs should have session on National Health Programs, Medical Laws, Insurance, Medical Audit, Recent Advances, and Newer Treatments etc.

8) How about teachers and students—Senior practitioners, Medical Administrators, authors, speakers, letters to the editor, conferences etc?

Senior practitioners are not exempt from the scheme.

Doctors working as Medical Administrators are not exempt from this notification.

Teachers & PG students get 4 Credit Hours per Year, automatically, hence they have to earn 2 more hours.

4 points allotted for National / State Conference of recognized body.

International CMEs / Conferences- Delegates get 4 Credit Hours and Speakers get 8 Credit Hours.

Speakers at Conference get 1 extra point.

Approved Journal Publication yield 4 points. Letter to Editor yield 2 points.

Credit hours are based on composition of Faculty participation, quality of subject matter and feedback forms from delegates.

Publication of Medical Text Book / Indexed Journal

a)	**Author / Editor**	**12 hours**
b)	**Author of the Chapter**	**4 hours**
c)	**Original Article in International Journal**	**12 hours**
d)	**Original Article in National Journal**	**10 hours**
e)	**Letter to Editor of Journal**	**4 hours**

9) Sponsored Programs, Promotional Programs by pharmaceutical companies, Institutes or Hospitalswill not be given any credit hours.

10) Organizers can charge registration charges for Credit Point CME Programs for the functioning and expenses of the CME.

11) Non Members of an Association can also attend the CME and can gain Credit Hours with Extra Fees for Registration Charges, if space is available.

Such Programs are already organized by Poona Ophthalmological Society, Indian Medical Association and various Speciality Organizations.

Now that MMC has made it adequately public about credit hours, no excuses will be heard by them for not obtaining credit hours by Feb 2012. Ignorance of law is never excused and hence all Medical Practiners are expected to accrue Credit Hour points for further renewal of their Medical License.

For any queries contact the authors.

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THE SECOND DECADE OF 21ST CENTURY

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Dr. Daljit Singh has straddled many generations of ophthalmology practitioners. He writes here to give a small peak in times gone by, to an era few amongst us would remember.

It is good to review how much has changed in one life. In 1950, you could buy one surgical instruments set, to do every kind of known eye operation, for about 2000 rupees. Today even a single needle-holder costs more than that. An ophthalmologist's time was lost mostly doing refractions. The surgical lists in Eye department of Medical College Amritsar for one busy day were like- 35 cataract, two optical iridectomy, three trephine, 2 dacryocystectomy, 5 entropion and 2 evisceration cases. Local anaesthesia was with novocaine (freshly prepared from powder and distilled water by the anaesthetist). One drop of cocaine was used for surface anesthesia. No adrenaline was mixed with novocaine, with the result that a good anesthesia lasted for less than 5 minutes. The surgery had to be completed within that time. A longish surgery like strabismus was a problem if not supplemented with morphine injection. In 1961, readymade Novocain injection with or without adrenaline became available to be followed by lignocaine injection, that considerably improved local anaesthesia. Before 1956, most cataract surgery was done without a single suture. The patient was carried on a stretcher and he had to lie still on the bed for many days. Iris prolapse was a common feature. It was left as such or was simply cut and the wound allowed to heal. Aphakic glasses were mostly simple spherical glasses ranging from +8 to +14 D, that could be had for less than 5 rupees. They were mounted on wire frames, that would snugly go over the ears. There were few to none cars on the roads. These patients could safely cross the roads with aphakic glasses. Becoming re-sighted was the most important thing. The quality of life was rarely talked about. Few people went back to their original jobs. Aphakes mostly led “retired” life. Getting retinal detachment was the end of the road, as RD surgery was primitive and rarely done.

A large volume of surgery was done in the camps. There were few eye surgeons in the country and they were all in great demand to conduct free eye camps, where scores even over a hundred operations were performed in one day. A large number of cataracts were hypermaturemorgagnian, that showed their age. The morgagnian cataracts were done extracapsular. No saline was used to irrigate the anterior chamber.

Gloves were unheard of. The surgeon washed his hands once with soap and water. Between surgeries, the hands were dipped in mercury chloride solution or wetted with methylated spirit.

Ward rounds were an important ritual, when the operated eyes were opened and examined and then re-bandaged. The re-rolling of the used bandages was an interesting spectacle. An assistant was known for his skill in tying the bandages properly.

There were few medicines in the wards. Freshly prepared penicillin streptomycin drops, atropine eye ointment, acriflavin, mercurochrome andargyrol drops, and terramycin eye ointment.

In the outpatients the medicines prescribed were sulphacetamide drops, zinc-boric drops, boric acid powder, argyrol drops, dionine drops and yellow ointment of mercury. Then came penicillin, aureomycin, terramycin and chloromycetin eye ointments. Then came steroids. For glaucoma we had pilocarpine and eserine drops.

Carbolic acid, tincture iodine, copper sulfate and silver nitrate applications were used in different conditions of the cornea and conjunctiva.

Life has changed for the better, there is no doubt. Health care has improved for everyone, including the poorest amongst the poorest, though not at a uniform standard. The role and responsibilities of the ophthalmologist have increased, because of a bewildering range of technologies and techniques that have surfaced. Another feature of our age is the professionals getting wooed and bewitched and controlled by the big pharma, laboratory and manufacturing sectors.

Let us share our experiences in different areas of our diverse countries.

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AVASTIN GROUP- A SOCIAL INITIATIVE

Brig Ajay Banarji, Col VS Gurunadh, Col Poninder Kumar,
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Neovascular age-related macular degeneration (AMD) is one of the leading causes of irreversible blindness in elderly by causing a choroidal neovascular membrane (CNVM) which leaks fluid or blood into the sub-pigment epithelial or sub-retinal space. The predominant mediator of neovascularisation is vascular endothelial growth factor (VEGF). Where once there was no hope for these patients, today, with the advent of VEGF inhibitors like bevacizumab (Avastin), ranibizumab (Lucentis) these patients can hope for some visual gain. Ranibizumab is the only FDA approved anti-VEGF, however the high cost of the drug precludes its routine usage. Bevacizumab (IVB) is a full-length, recombinant, humanized, monoclonal antibody and is directed against all VEGF isoforms. Bevacizumab is extensively used off-label as anti-VEGF molecule and has been found to be safe and efficacious. Around 40 individual doses can be reconstituted from a single vial of bevacizumab, and equal number of patients can be injected making it a cheaper alternative, especially in a developing country like ours.

The Department of Ophthalmology, AFMC Pune started a pilot project of use of bevacizumab in patients of neovascular AMD in 2007. The initial patients of"Avastin Group" were patients of neovascular AMD. Proper case selection was done based on vision, fundus fluorescein angiography and optical coherence tomography picture. The patients were given intra-vitreal injection of bevacizumab once a month, free of cost. Since the treatment modality involves reinjection in almost all patients to maintain the visual benefit, patients of the group helped and supported each other. Each was encouraged by the other's improvement and this helped both patients and treating physician alike. Overall, till now more than 150 patients have received treatment and have shown favorable visual outcomes. In recent years the use of anti-VEGF has increased and encompasses other diseases. This has led to the expansion of "Avastin group" which now includes the patients of proliferative diabetic retinopathy, recalcitrant clinically significant macular edema, vascular occlusions, neovascular glaucoma and corneal neovascularisation.

"Avastin group" of patients have been helped immeasurably by this treatment as it has offered a glimmer of hope in their otherwise life of darkness.

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BOOK REVIEW –STEP BY STEP SQUINT SURGERY

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Dr. Prasad Walimbe, an eminent member of the Poona Ophthalmology Society has written a book on strabismus surgery- Step by Step Squint Surgery.

A small pearl that is easy to carry and easier on the eyes, it encapsulates the basic principles of strabismus surgery planning and pitfalls. It has something for novices and experts alike- for the former it makes the job of understanding strabismus surgery easier, and for the latter it's a quick revision to this slightly volatile subject. The great German philosopher, Immanuel Kant wrote, 'It's difficult to understand, but it's worth all the trouble trying to do so.' This aptly sums up strabismus management; through tricky to understand, the results are gratifying. We should thank Dr. Prasad, our very own Puneri, for making this task of understanding easier for us.

The book has numerous authors- national and international adding to its perspective and depth.

The colored diagrams are illuminating as also the brief accompanying text. Mercifully the authors have not elaborated on the numerous theories in strabismus and thus made the book readable for the general ophthalmologists. Its small size shall invite the 'rare' readers who find large tomes intimidating.

As someone who fancies himself as a strabismologist, I found the lack of chapter on 'Why to treat Strabismus and importance of early management, especially surgery' disappointing. Many ophthalmologists ignore this 'problem' of the patient thinking it unworthy of attention. Hopefully the authors would add a chapter on 'why treatment is useful' and how it helps to improve patient satisfaction and help vision function, in their subsequent editions.

The chapters by the faculty at Aravind are illuminating, especially the 'principles of strabismus surgery' by Dr. P. Vijayalakshmi, the chief of the pediatric ophthalmology department and Dr. Milind Killedar's chapters on preoperative counseling and post operative care are helpful. The last chapter, 'What's new in strabismus' by Stephen Craft gives us an overview of what new coming up in a sub-specialty that has been termed 'static'.

Dr. Prasad needs to be commended for his efforts in compiling so many write ups and making them presentable and easy to understand for novices and experts alike.

We should also congractulate Dr. Prasad for his noble gesture of donating the proceeds from the sale of this book to' Poor Children Spectacle Fund of Arvind Eye Hospital, Madurai

We hope Dr. Walimbe the very best and hope this is just the first book he has written and thank Jaypee Brothers for publishing this very useful book on an important but understated topic- strabismus surgery.

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DIAL 'M' FOR MOBILE MEDICINE

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Whatever we receive is information. Whatever we preserve is knowledge. Whatever we use is wisdom and How and When we use it is 'Intelligence'

Information is king, perhaps only if available at the right time & right place.

Ophthalmology, like all other specialties in medicine is an ever expanding sea of knowledge. The important point is to get the right piece of information from this vast ocean. In the olden days reading books or journals was the primary source of information, a 'luxury' which few had access to. Internet has changed all that.

Today all that information can be accessed at the click of a few thumb punches on your mobile phones. With the advent of Smartphones, it has become very easy to not only get information on any field, but also these devices can be used in multitude of ways for professional use.

In a survey conducted amongst US physicians in 2010, over 90% of physicians were accessing a variety of information over their mobile phones, up from 59% in 2006.

Applications or 'Apps' are customized programs built for specific purpose. The Apple iPhone and iTouch have the highest number of apps, because this was one of the first such device in the market & also because it's operating system is user & developer friendly. Google Android based phones has now many of the apps available on Apple.

The computing power in an average Smartphone is much faster than a 10years old Desktop computer.

One can choose from five software platforms-Apple, Blackberry, Google Android, Windows Mobile and Symbian that dominate the market share.

Let's look at some of the applications for an Eyecare Physician for ones smartphones.

By downloading Electronic Medical Record software built for Mobiles, patient info can be accessed anytime, anyplace.

High quality clinical images- Slitlamp, Fundus photos, OCT, Perimetry charts can be accessed on these devices.

(This technology is widely used by the ROP team at Narayan Netrlaya, Banglore and at H V Desai Eye Hospital ROP programme)

One can click very good quality slitlamp & even fundus images with the mobile camera. This can be very useful for maintaining patient record, for patient education or even for seeking opinions from other specialists.

One can download Snellens Acquity charts, Colour vision charts or Amsler grid, which can be handy in Emergency rooms or non-office settings.

Softwares like Epocrates gives you all the information about drugs and their interactions.

Free iphone apps like 'www.eyehandbook.com' are handy for quick reference. Paid apps like Wills Eye Mannual are also available for the mobile platform.

Certain apps like 'www.docapps.com' are free for patients use, but subscription based for physicians. It enables a physician to set up a customized app for connecting patients to his or her office. Imagine if a LASIK surgeon tells patients to download his app on iTunes and view a video about the surgery. That has a 'cool' factor to it. Physicians can dynamically add or change content on their app on the fly, using the web interface. They can change the content of their app by themselves, just by going in and editing. And whenever they change anything, it repopulates the info to all the users of the app.

Most of the apps that are free for the end user generate revenues through advertisements. But these adverts are not intrusive and do not disturb your attention.

A virtual pandora's box has opened up with the introduction of Smartphones and similar devices (Apple iTouch and Samsung Galaxy Tab).

We as physicians now need to learn to customize the best application's suitable for us and use this technology judiciously to the best of our & our patients advantage.

WHICH APPS? NINE WEBSITES TO GET YOU STARTED.

Go online to find out which apps are available for the various types of smartphone.

News about medical apps and smartphones—www.imedicalapps.com and www.medicalsmartphones.com.

Latest iPhone/iTouch medical apps—iphonemedicalapps.com.

For Academy content on the iPhone, including select *Summary Benchmarks* and patient education videos, as well as a link to EyeWiki, see the Eye Handbook—www.eyehandbook.com.

Best 60 Android apps for medical professionals—www.softwareadvice.com/articles/medical/the-best-android-apps-for-doctors-nurses-and-health-care-professionals-1062810.

Android health apps—search for "medical" at either www.androlib.com or www.androidzoom.com.

Lists of medical apps for Symbian devices—www.allaboutsymbian.com/software.

Overviews of issues in mobile medicine—mHealth Initiative website at www.mobih.org.

Refrence:

Practice Perfect: Information TechnologySmartphones in Practice: Dial "M" for MedicineBy Linda Roach, Contributing EditorInterviewing Ken Lord, MD, Rob Melendez, MD, MBA, and Vinay A. Shah, MDEyeNet Magazine, February 2011

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