A TO Z OF ELECTRONIC MEDICAL RECORD

Speaker: Dr. Sujeet Chaterjee, CEO, Dr. L N Hiranandani Hospital, Mumbai

The session began with a comprehensive definition of MEDICAL RECORD "as a health record or medical chart which is a systematic documentation of a patient's medical history and care" and use of this term both

- ✓ for the physical folder for each individual patient and
- ✓ for the body of information which comprises the total of each patient's health history

TREND WHICH HAS BEEN SO FAR:

family doctors and other health care providers charted patient information manually in paper charts

⇩

Personal health records were maintained by individual patients (have become more popular in recent years)

⇩

The information contained in the medical record allows health care providers to provide continuity of care to individual patients

Importance of Medical Records

- It is a LEGAL document evidence (as per the Indian Evidence Act, 1872)
- Records are summoned to the court of law in medico legal cases
- Retention & Destruction of Medical Records: In India there are no clear cut guidelines or law regarding the same, though allowing access to the patient's records are mandated in accreditation standards like the NABH. However, as per good practice, the patient files are stored for a periodic term as follows:

- OPD records 5 years
- IPD records 7 years
- Medico-legal cases: 15 years

- All medical records can be destroyed after the mentioned time. However as a good practice, the hospitals publish an advertisement in the news papers for the concerned to take claim of their records
- EHR, here is a boon as these records can be scanned and digitized and can be made available for posterity. The storage spaces for hard disks etc have become very cheap and cost effective

Electronic Medical Records - the changing trend:

- Paper based records are being gradually replaced by computer based records(which is in existence in the West since 2 decades)
- It has not achieved the same penetration in healthcare as in finance or other industry. Deployment varies in countries

Some definitions – As given by the National Alliance and Health Information Technology (NAHIT)

- **EMR – Electronic Medical Record**: The electronic record of health related information on an individual that is created, gathered, managed, and consulted by licensed clinicians and staff from a single organization who are involved in the individual's health and care.
- **EHR – Electronic Health Record**: The aggregate electronic record of health-related information on an individual that is created and gathered cumulatively across more than one health care organization and is managed and consulted by licensed clinicians and staff involved in the individual's health and care.
- **PHR :** An electronic, cumulative record of health related information on an individual, drawn from multiple sources, that is created, gathered, and managed by the individual

The Difference between EMR & HER

- The key word is Medical & Health –

EHR provides a comprehensive view of the patient's health history, clinical findings that have been collated over time and is more of a comprehensive collection of medical data	EMR is a record of single diagnosis or treatment which is maintained in separate compartments to be used by specialist concerned with the single disease. It is more of a standalone data but not sufficient for comprehensive integration to come to a diagnosis

Checkpoints for converting paper based records into electronic form:

- Security of patient information
- Privacy of the records
- The integrity of the records
- The integrity of the clinical work flow supported by the medical records
- Continuity and quality of patient care through the transition-the records should cover all the details of the medical history of the patient and the electronic system should be able to utilize it in delivering total care to the patient

Key capability of the EMR

- Captures data at the point of care
- Integrates data from multiple internal (within the hospital, between various departments like radiology, laboratory, etc.) and external sources (between various independent hospitals) i.e. compatibility between various soft wares used by different hospitals is very important to ensure efficient utilization of this feature
- Supports caregiver decision making

Electronic Medical Records – Benefits

- Health Information and data – Diagnosis etc.
- Result management – quick and easy
- Order management – Ability to enter prescriptions based on the entire medical history of the patient which in turn ensures patient safety
- Decision support – algorithms stored help you to follow a standard format for treatment of different patients
- Electronic communication and connectivity as the data is readily accessible
- Patient support – provides data for patient education
- Administrative processes – helps in scheduling systems
- Reporting – In its various forms, surveillance etc
- Doctors handwriting-bypasses the difficulties faced due to illegible writing of doctors and other staff handling the data
- Easier tracking by the care giver
- Data storage and retrieval - patient care delivery is quick and with utmost efficiency
- **Universal Accessibility-** Providers can view or edit patient data from a desktop, handheld device or PC at their convenience
- **Informed Decision Making -** A one-click search allows instant retrieval of patient notes, medications and vital documents – saves on time
- **Specialty Specific Customization –** helps in smooth functioning through ensuring compliance which in turn results in detailed documentation as well as accurate chart coding and diagnosis
- **Interpretive Reporting –**Users can formulate exhaustive reports by demographics, insurance, ICD/CPT Codes
- **Integrated Workflow –** quality of care highly improved and helps in creating conducive work environment through coordination among providers, nurses and other staff
- **Scope for research initiatives**

Data Retrieval – Manual

Onsite	Off site
MEDICAL RECORDS DEPARTMENT (MRD)/ IPD **The in-charge is a doctor** **Patient files are kept with the patient registration number in series and year wise** **The storage is in compactors – All documents are scanned** **Proper authorization process to release the document** **Tracking** **Return** **Copies are to be paid for**	**OUTSOURCE A PROFESSIONAL ORGANIZATION** **Year ending, the previous years documents are marked** **The agency packs and removes the document offsite** **The storage is done in fair weather conditions including humidity test. No pests** **Proper authorization process is followed** **Document is recovered in 48 hours** **For immediate sourcing – Additional charge or if not possible then the hospital can print a case paper as all documents are scanned** **Copies are to be paid for**

Data Retrieval – Dos and Don'ts

There are some simple steps you can take when responding to requests for medical records for legal process:

- Determine if the request is valid-verify identity and authority of the requestor. Request legal picture identification, such as a driver's license or passport.
- Validate that the format of the request meets the legal requirements
- Patient or legal guardian request via phone-information may not be disclosed without written authorization.

- Patient or legal guardian request via e-mail-these requests are difficult to authenticate. Not yet clear in India

- Patient or legal guardian request via formal HIPAA-appropriate written authorization-information may be disclosed according to patient or legal guardian wishes.

- Legal request from the Police or law enforcing agency and they have to sign the photocopies which need to be numbered

- Court order for documents is legal but the same process as mentioned above should be followed

- Disclose the information to the designated recipient only.

Disadvantage of EMR

- EMR has been less effective than anticipated
- Lack of standardization of clinical terminology
- Admission and discharge data are unstructured
- Unauthorized access to privileged information
- System crash – Back up must be an integral part

Conclusion

The transition to electronic records represents a significant change to the clinical process in medical practice. These changes must be carefully considered to ensure patient safety and quality of care throughout the transition process. It will be through the integration of medical records and clinical processes. We must ensure patient privacy and information security.

Healthcare Operations: National v/s International

Dr Azad Mopen, MD

Salient Features: Gulf Cooperation Council Countries

Health Systems & demographic challenges

He spoke about the salient features of GCC healthcare . The service out there is a hybrid of both government & private institutions. The funding is mainly by the government with a growing presence of insurance. With regards to the demographic features, in Dubai there are more than 100 nationalities with more than 75% being expatriates. The majority of the population is working class and hence the disease profile is specific to them. Also, there are many people from countries in Africa and hence there is a high probability of importing exotic diseases. Knowledge of local language is essential . The health sector is also strictly regulated by the government.

Delivery of Healthcare

In the GCC, primary care is provided by combination of public & Private sectors with a predominance of private players who cater for the expatriates. Secondary & tertiary healthcare is provided mostly by the public sector. Emergency care is almost excludively provided by the government & is free of cost. High tertiary care is still an emerging sector & currently majority of the patients seek treatment abroad.

GCC Regulations & Quality Control

There are strict regulations for establishment of healthcare facilities. Licencing of healthcare technical staff is cumbersome. CME credits are becoming mandatory. Re- licencing has started in some countries. Accreditation requirements are becoming stricter. Frequent inspections are conducted by various agencies.While employing new staff, a compulsory document verification is done by getting them authenticated by the issuing university.

Opportunities in GCC for Indian Healthcare Industry

- Source of Trained Healthcare manpower – There is a tremendous shortage of trained manpower & this can be deficiency can be tapped by professionals who wish to explore their opportunities in the Gulf.
- Medical Value Travel – There is a booming trend in this area with many success stories but what has been seen is only the tip of the iceberg so there is a huge potential for

specialized organisations in India, provided they are able to maintain established International standards.

- KPO…Tele-Radiology and Pathology Services – Pathology samples could come to India rather than being sent to Europe . for this, the labs need to standardize themselves by undergoing accreditation procedures.
- Visiting Consultants – Specialists from India can carry a consultation practice in the GCC.
- Hospital Operations Management/HMO – Government is gradually entrusting management of hospitals to private institutions. There is a growing managerial talent pool comprising of many experienced healthcare managers who are opting for GCC countries, thus emphasising the vast potential opportunities available.
- Health Insurance Operations – There is a gradual increase in health insurance and this represents a growing opportunity to organisations who can provide the same.

Indian Hospital Management

This was lucidly explained by referring to the lessons through their Calicut based hospital MIMS which was the first multispeciality hospital in India to get NABH accreditation. The importance of strategic planning was stressed upon and it was said that it should include an understanding of gaps between demand and supply, defining and exploring the opportunities available. One should develop an optimal model including key input of capital 7 people with a focus on futuristic growth.

Healthcare projects are generally high capital expenditure projects and due care should be given to cost and time escalation as if they are not planned properly , it can lead to failure of project. Professional advice should be taken at all times like for eg, while procuring equipment, Dr Moopen related how inspite of his expertise in certain departments, he still found them deficient when compared to professional analysis. He also stressed upon the importance in coupling of finishing and operationalising the institution.There should be seamless transition between the two.

HR Challenges

Greatest challenge in healthcare scenario is human resource. People build the organization and hence due importance should be given to them. Compensation packages should be satisfying and due consideration should be given to how satisfied they are to be a part of the organization. This helps in reducing staff turnover.

IT Challenges in Healthcare

There is a resistance to change by doctors and as per his experience, management should vary from persuasion to coercion to inculcate IT in hospitals. Doctors who were the strongest opposers initially were now the best believers in the benefit of IT in making the job easier.

He brushed through the best practices in healthcare which are

- Define Best Practices
- Patient-centric approach
- Protocol based care
- Continuous Monitoring
- Non Medical touch points
- Advisory Board with Doyens
- Bench mark with Model Institutions

Accreditation

He said accreditation is not an end but a beginning and requires dedicated management involvement. It also helps in branding and image building of the organization which in turn attracts staff & patients to the hospital.

He spoke about the perils and evils in healthcare and mentioned briefly about medical negligence, malpractice, Public interface and abuse of healthcare professionals and the need for strict government regulations regarding the same . With regards to kickbacks, he said it's a sad practice and organizations should have a strict policy not to encourage it.

Question Answer Session

Q1) Major Challenge in IT implementation is resistance from doctors and most of the times, they themselves are not aware of what is required so how should this be addressed?

Ans. Dr Moopen answered that IT implementation should be done in a phased manner by first identifying and involving certain keen and inclined doctors, as a pilot project they should be started in a few low load departments and once they are smoothly running it should be extended to the other departments. Due patience and strong guidance should be provided during the entire process which sometimes can take almost 2 to 3 yrs. Doctors should be explained the current and long term benefits that they will derive by the implementation of IT in hospital.

Q2) what is considered a fair return on investment in hospitals?

Ans. ROI in healthcare depends on the procedure and capital invested. One can expect a decent ROI of 60-70% in the lab. The best policy out here would be to transfer this profit to the consumer in the manner of concessions. This in the long run helps build further profits by increasing patient inflow

Healthcare Professional and Law

Dr. Sanjay Gupte . M.D. D.G.O. F.I.C.O.G. L.L.B President (Elect) FOGSI

There are two types of laws.

Statuatory laws:laws enacted by the parliament.

Case laws: Higher courts give decision which are yardstick to lower courts.

Laws applicable to medical practitioners

- **Medical Termination of Pregnancy Act (MTP act)**

  It was enforced from April 1972.The law laid down parameters about who,when ,where will carry out MTP.It also laid down specific methods to conduct MTP.

- **PCPNDT Act**

  The law was enacted in 1994 for regulating use of prenatal diagnostic techniques.The law prohibits sex selection & prenatal sex determination.Both these laws have punishment under Indian Penal Code for contravention.

- **Registration of Birth & Death**

  Birth and death should be registered with local authorities within 21 days of occurrence. The onus on the attending physician.

- **Medical Council of India Act (1956)**

  The law governs all medical education & practice in India. Registration with MCI is essential for practicing with state medical councils which are under MCI.

- **Bombay Nursing Home Registration Act(1949)**

  The law was passed for registration & control of nursing homes.Various state acts are now in place on the same lines.

- **Labour Laws and the Medical Establishment**

- **Shop & establishment act**

- **Bio medical waste management act(1998)**

  This is an act directing the disposal of bio medical waste from healthcare facilities in a proper manner.

- **Consumer Protection Act**

- **Indian Penal Code**

Land Mark Cases:

CASE 1:

Dr. Laxman Balkrishna Joshi vs. Dr. Trimbak Bapu Godbole and another AIR 1969 SC 128

A patient had suffered from fracture of the femur. The accused doctor while putting the leg in plaster used manual traction.He used excessive force for this purpose; with the help of three men.Such traction is never done under morphia alone but done under proper general anesthesia. This gave a tremendous shock causing the death of the boy.

On these facts the Supreme Court held that the doctor was liable to pay damages to the parents of the boy. The following legal principles were laid down.

- A person who holds himself out ready to give medical advice & treatment impliedly holds forth that he is possessed of skill & knowledge for the purpose.
- Such a person when consulted by a patient, owes certain duties, namely, a duty of care deciding whether to undertake the case, a duty of care in deciding what treatment to give, & a duty of care in the administration of the treatment. a breach of any these duties gives a right of action of negligence against him.
- The medical practitioner has discretion in choosing the treatment, which he proposes to give to the patient, & such discretion is wider in case of emergency, but he must exercise a reasonable degree of care according to the circumstances of each case

CASE 2:

Indian Medical Association vs. V.P. Shantha 1995(6) SCC 651

This landmark judgment decided that service rendered by medical professional comes under section 2(1)(0) of the act & hence the consumer protection act was applied to the medical practitioners.

Interestingly this decision also directed that complex medical situations should be sent to the civil courts .

CASE 3:

Pt. Parmanand Katara vs. Union of India & Others AIR 1989 SC 2039

The petitioner referred to a report published in the newspaper "The Hindustan Times" in which it was mentioned that a scooterist was knocked down by a speeding car. Seeing the profusely bleeding scooterist, a person who was on the road, picked up the injured and took him to the nearest hospital. The doctors refused to attend and told the man that he should take the patient to another hospital located 20 kilometers away authorized to handle medico-legal cases. The injured was then taken to that hospital but by the time he could reach, the victim succumbed to his injuries.

CASE 4:

Samira Kohli V/s Dr. Manchanda, Case No. CA 1949 of 1004

Supreme Court of India has come out with very important judgment in case of decided on 16th January 2008 regarding **CONSENT FOR SURGERY**

Appellant went to respondent's clinic with her mother. On admission, the appellant's signatures were taken on consent form for diagnostic and operative laparoscopy on 10.5.1995 – appellant was put under GA and subjected to a laparoscopic examination. When the appellant was still unconscious, assistant doctor came out of the Operation Theatre and took the consent of appellant's mother, who was waiting outside, for performing hysterectomy. Thereafter, the Respondent performed a abdominal hysterectomy and bilateral salpingo-oopherectomy.

Hon. Supreme court has summarized the principles relating to consent as follows:

The consent so obtained should be real and valid, which means that; the patient should have the capacity and competence to consent. The consent should be voluntary;

The adequate information to be furnished by the doctor (or a member of his team) who treats the patient.

Consent given only for a diagnostic procedure, can not be considered as consent for the therapeutic treatment

CASE 5:

Rajesh Kumar Tiwari (Dr.) v. Ramswaroop Rathore (2007) July CPJ

Death due to administration of injection – *Res ispa loquitur* applicable – Treatment by O.P., as Ayurvedic doctor who is not qualified for allopathic treatment .Hence negligence was proved.

CASE 6:

Mohammad Ishfaq v/s Martin D'Souza, Nanavati Hospital. Feb 17 ,2009

In this case Mr. Ishfaq suffered hearing loss due to Amikacin Inj. & National Forum in 2002 awarded compensation of 7 lacs by the doctor. The Supreme Court over ruled the judgment commenting that extra ordinary situations require extra ordinary remedies, & here doctor has to choose between devil & the deep sea.

A brilliant judgment was given by Hon.***Justice MARKANDEY KATJU & Justice R. M. LODHA*** clarifying many grey areas.After referring to the judgment by Justice McNair in Bolam's case & Halsbury's Laws of England, The Hon. Justices have lucidly formulated following guidelines

1. A medical practitioner is not liable to be held negligent simply because things went wrong from mischance or misadventure or through an error of judgment in choosing one reasonable course of treatment in preference to another. He would be liable only where his conduct fell below that of the standards of a reasonably competent practitioner in his field.

2. There is a tendency to confuse a reasonable person with an error free person. An error of judgment may or may not be negligent. It depends on the nature of the error.

3. It is not enough to show that there is a body of competent professional opinion which considers that the decision of the accused professional was a wrong decision, provided there

also exists a body of professional opinion, equally competent, which supports the decision as reasonable in the circumstances.

4. The standard of care has to be judged in the light of knowledge available at the time of the incident and not at the date of the trial.

5. Simply because a patient has not favourably responded to a treatment given by a doctor or a surgery has failed, the doctor cannot be held straightway liable for medical negligence by applying the doctrine of *res ipsa loquitur*.

Protection to doctors in criminal cases

1. A private complaint should not be entertained unless the complainant has produced prima facie evidence before the court in the form of a credible opinion given by another competent doctor to support the charge of rashness or negligence on the part of the accused doctor.

2. The investigating officer should, before proceeding against the doctor accused of rash or negligent act or omission, obtain an independent and competent medical opinion, preferably from a doctor in government service, qualified in that branch of medical practice who can normally be expected to give an impartial opinion applying the Bolam test.

3. A doctor accused of negligence should not be arrested in a routine manner simply because a charge has been leveled against him. Unless his arrest is necessary for furthering the investigation or for collecting evidence or unless the investigating officer feels satisfied that the doctor proceeded against would not make himself available to face the prosecution unless arrested, the arrest should be withheld.

Other landmark cases discussed were as follows:

CASE 7: Poonam Verma vs. Ashwin Patel & Ors. (1996) 4 SCC 332

The professional may be held liable for negligence on the ground that he was not possessed of the requisite skill which he professes to have.

CASE 8: Sarwat Ali Khan vs. Prof. R. Gogi and others Original Petition No.181 of 1997,decided on 18.7.2007 by the National Consumer Commission

CASE 9: Dr. Sr. Louie and Anr. vs. Smt. Kannolil Pathumma & Anr.

The National Consumer Commission held that Dr. Louie showed herself as an M.D. although she was only M.D. Freiburg, a German Degree which is equivalent to an M.B.B.S. degree in India.**(misrepresentation of skills)**

CASE 10:Spring Medows Hospital & Another vs. Harjol Ahluwalia thr' K.S.Ahluwalia & Another (1998) CPJ 1

CASE 11: Sethuraman Subramaniam Iyer vs. Triveni Nursing Home and Another(1998) CPJ 110

Bad outcome doesn't mean negligence

CASE 12: State of Punjab v/s Shiv Ram (2005)Dec CPJ

Sterilization failure: Operating surgeon or employer not liable.

Torts: Medical Negligence : Damages: Birth of child after sterilization operation: Merely because woman having undergone sterilization operation became pregnant and delivered child, operating surgeon or his employer cannot be held liable for compensation on account of unwanted pregnancy

CASE 13: 2005 AIR SCW 3685 (From: Punjab andHaryana) R.C. Lahoti, C.J.I., C.K. Mathurand, P.K.Balasubramanyan, JJCriminal Appeal Nos. 144-145 of 2004 D/5-8-2005. Appellant: Jacob Mathew Vs Respondents: State of Punjab and others

This case laid down the guidelines for prosecuting medical professionals

CASE14 :(ANAESTHESIA COMPLAINT) Karam Veer Singh v. Garg Nursing Home (2007) July CPJ

CASE15: RashmiVora v.ArunabenD.Kothari (2005) Dec CPJ

CASE 17: Sushma Sharma v. Bombay Hospital (2007) June CPJ

CASE 18 :(DOCTOR'S PRESENCE)Naseem Mohammed Bashir Ansari v. Dhange Hospital - (2007) June CPJ

CASE 19 :(LOCUM ARRANGEMENT)Nabhan Farhan Sah v. Latha Sharma (Dr.) (2007) June CPJ

CASE 20: ParmodGrover v.ManvinderKaur(Dr.) (2007) June CPJ

CASE 21: BhagwatiDevi v.S.M.G. Sonography Centre(2007) June CPJ

Case of mistaken diagnosis.

CASE 22: Rajesh Kumar Tiwari (Dr.) v. Ramswaroop Rathore(2007) July CPJ

Death due to administration of injection – *Res ispa loquitur* applicable – Treatment by O.P., as Ayurvedic doctor – Not qualified for allopathic treatment – Negligence proved**.**

CASE 23: Mohammad Ishfaq v/s Martin D'Souza, Nanavati Hospital. Feb 17 ,2009

<u>CONCLUSION</u>

When we look at this fascinating spectrum of development of Indian Medical Law scenario one must say that in last 20 years it has now substantially matured. The judiciary is trying its best to produce a balance between the patients & doctors interests. Now is the time when medical organizations should also come forward to take this initiative further

HEALTHCARE COMMUNICATION: BANDING & MARKETING

Panel Members: Mr Vivek Shukla, Dr P.K. Grant, Mr Sanjay Kakade

Chairperson : Prof Ujjwalkumar Chowdhury, Director, SIMC

Prof Ujjwalkumar Chowdhury commenced the session by impressing upon the importance of advertising, branding and communication in healthcare. It is a means of introduction of services and products. Tangible, credible and authentic branding is important.

He put across 3 aspects to be pondered upon

1. Integrated Social Marketing: it is 360 degree branding proposition
2. Experiential marketing or Buzz marketing creates a brand as against advertising which only role informs.
3. What is the role of social, digital media in healthcare?

MR VIVEK SHUKLA, Healthcare Marketing Consultant

Business of branding- You can influence what other people can think if you only know what to ask.

- 2 pillars of communication

1. Advertising
2. Public relations

More of PR and less of Advertising

- PR is about media and events (camps etc)
- Advertising- electronic, print and outdoor

Public Relations

- Non paid medium of promotion.
- 3rd party endorsement.
- No control on PR, whether positive or negative impact

Advertising

- Paid
- 1st party
- Controlled

Build a brand on PR and sustain with advertising

- Example of creating a PR Advertising Mix
  A 100 bedded hospital in growth phase, with 78% cases from referrals
  Strategy was to focus more on PR than advertising.
  PR focus was on events. Some electronic PR like case studies, interviews. Outdoor PR is more emphasized.

- Examples of Brands built on PR
- Blackberry
- Harry Potter
- Star Bucks Coffee
- McKinsey & Company
- Ghajini

- Press management
- Know how to handle the press
- How to make press notes
- Single spokesperson for the press

- Press coverage- examples
- Eg. Free nebulizers distributed and teachers trained after the case where a girl in school dies because of an asthma attack
- The people have to talk about your brand. Only then PR is successful.
- The timing of you PR event is crucial.
- Event coverage followed by tongues wagging
- Eg. Fund raising by a hospital. Included rally, fund raising dinner

- Online PR

Tools for online PR are

- Blogs- especially for international pts, social networking sites
- Interactive websites- more effective than just informative websites
- Viral marketing- you create an email that is sent to many people, who in turn send it to others. This creates a chain of emails. Eg an email with a calculator which tells you how much water you should drink

- **Advertising**

- Some amount of blowing your own trumpet is important
- Centre of good advertising is emotion. Emotions such as peace of mind, reliability, safety, trust is applicable for hospitals

Other aspects

1. Intervention value- catches attention
2. Entertainment
3. USP- unique selling proposition
4. Action- have to put customer into action ie sales. Tell them where to buy.

- **Internal communication**

- Your own people should be ready to mach up to your branding experience.
- Your people have to believe and deliver consistently

Prof Ujjwalkumar Chowdhury,Director,SIMC

Comments:-

- Professionals generally use their rationality, objectivity and logical thinking.
- He explained the concept of AIDA for advertising which includes, Attention, Awareness, Interest, Desire and Action
- Satisfaction after sales service is also important to maintain the brand equity of your service or product.
- Your employees are the biggest internal brand ambassadors whereas successfully treated and satisfied patients are your external brand ambassadors.

Dr P.K. Grant, Consultant Cardiologist, Ruby Hall

- A hospital in today's world is a sophisticated hotel with good infrastructure and state of art equipments.
- It is a service industry and good service spreads by word of mouth
- Use of Hub and Spoke Model: Eg. Setting up peripheral MRI and CT Scan centres across the state of Maharashtra. These patients are then referred to Ruby Hall Clinic for any further intervention required.
- If you have the latest and best equipments with good service, patient follow up is inevitable.