FOR DOCTORS

BHARATEEYA STRATEGIC INTELLIGENCE

DOCTOR EDITION

The Clinic Call

You diagnose patients every day. Your own practice decisions go undiagnosed.



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The Seven Disciplines

One decision, carried through seven stages, in a fixed order.

V1 **Drishti** · *Reality*
What is the Maximum Friction?

↓

V2 **Nischaya** · *Direction*
Which direction removes it?

↓

V3 **Bodha** · *Stakeholders*
Who must align for this to succeed?

↓

V4 **Swadharma** · *Natural Strength*
What unique strength do I build on?

↓

V5 **Margarekha** · *Sequence*
In what sequence should this happen?

↓

V6 **Pramaan** · *Evidence*
What evidence proves this will work?

↓

V7 **Sadhana** · *Build, Fix and Scale*
What do I build, fix and scale?

↺ *Every cycle removes one friction and reveals the next*

Diagnose Design Prove and execute

BEFORE CHAPTER 1

Quick Start

Get One Decision Working in Two Pages

Do not finish this book first. Finish one decision first. What you write here is **provisional** until you complete the full V1 to V7 worksheets. Seven disciplines, fixed order: Drishti, Nischaya, Bodha, Swadharma, Margarekha, Pramaan, Sadhana. Carry one decision through all seven. Illustrative example: *Join two colleagues as a partner in a new children's centre only if the partnership deed gives me a clear exit at twelve months, and decline if it does not, before the lease is signed on Wednesday 30 June.* The full model is in Chapter 10, after you learn the disciplines.

Page 1. Choose, name, and aim

1. One real decision this week (a practice, hospital or career decision (not a clinical decision about a patient)):

_____

2. What is REALLY happening (one factual line; a number if you have one):

_____

3. Three friction points. Evidence you can point to today:

1. _____ / Evidence: _____
2. _____ / Evidence: _____
3. _____ / Evidence: _____

4. Candidate Maximum Friction (longest cascade is a clue; confirm the upstream cause):

_____

Mechanism (not the gauge alone): _____ **Measured today:** _____

Page 2. Direction through first action

5. Nischaya. Do: _____ Delay (when): _____ Delete (because): _____

6. Bodha. Builder / ask this week: _____ Who loses / what you will say: _____

7. Swadharma. Scarce strength for this direction:

8. Margarekha. What must happen first:

9. Pramaan. What would prove this wrong (write before you start):

10. Sadhana. Action this week: _____ Number watched: _____ Review date: _____

Take this same decision into Chapter 3 (V1), then V2 to V7, without switching problems. This is for practice and career decisions. Clinical decisions follow clinical evidence and the patient. Chapter 10 shows a completed illustrative walkthrough.

CHAPTER 1

Why Strategy Fails Before It Begins

Somewhere in your practice there is a problem you have already solved more than once.

You found it. You fixed it. For a few months it was quiet. Then the same issue came back in slightly different clothes, and you fixed it again.

Nobody was careless. The fix was sensible both times. And yet here it is.

This book is about why that happens, and why it matters most when you are about to resign, borrow, sign or build in a way you cannot easily take back.

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Every doctor wants a good outcome.

A full OPD without a two-hour wait. Procedures that pay for the equipment. A team that stays. Patients who come back and send

their relatives. A hospital contract that is fair. A practice that still makes sense in ten years, and some evenings at home.

To get there, most of us respond by acting. We print more pamphlets. We extend OPD hours. We buy the machine the salesman recommended. We sign up with one more insurance panel. We take one more visiting consultancy to keep the income steady.

Some of these moves work.

Many do not.

The common assumption is that a practice struggles because of competition, or because the location is wrong, or because patients do not value good doctors any more. But that is rarely where the failure begins.

Failure begins much earlier.

It begins when you fix the thing you can see before you understand what is actually causing it.

The Painkiller Worked

Imagine a patient walking into a hospital with a severe headache.

Without asking questions or running any tests, the doctor prescribes a painkiller.

The headache disappears for a few hours.

A week later, the patient returns with fatigue. The doctor prescribes vitamins.

A month later, the patient develops a high fever and is finally diagnosed with an infection that had been there from the beginning.

The treatment was not the problem.

The diagnosis was.

Notice the detail that makes this story dangerous, not just sad.

The painkiller worked.

The headache did go away. The doctor had evidence. The patient was satisfied for a while. Nothing in that first visit looked like a mistake. If the patient had never come back, everyone would have called it a success.

That is why wrong diagnoses survive. They succeed a little, immediately, in a way that is easy to point at.

A clinic works the same way. Footfall drops after a new diagnostic centre opens down the road. The doctor puts a hoarding at the junction and offers a free camp. For a month the OPD is busy. The reason old patients stopped returning, a receptionist who sends follow-up patients home when the doctor runs late, was never touched.

The Reasonable Decisions

Doctors make this mistake every week.

The OPD is slow, so the doctor adds evening hours. A nurse leaves, so the clinic raises the salary for the next one. Insurance

payments are delayed, so the doctor asks the billing assistant to call the TPA every day. A procedure line is not paying, so the doctor buys a better machine to attract more cases.

Each decision looks reasonable. Each one addresses the problem that showed up.

And each one produces something. The evening OPD does bring some patients. The new nurse does join. Some claims do get paid. There is always something that improves, and there is always a number in the register that looks better.

Yet, after a few months, the same issue returns.

Why?

Because the doctor treated the symptom instead of understanding what was creating it.

What It Actually Costs

We tend to describe a wrong diagnosis as time lost. That undersells it.

A wrong diagnosis is not a pause before the right one. It costs your practice and you in three separate ways, and the third is the one that shapes your future.

It spends the budget of the correct decision. Your savings, your borrowing limit, your family's patience, your own energy after a

long OPD. You can only take one large loan at a time. Spend it on the wrong machine and it is not there for the right move.

It manufactures evidence. A year of camps, hoardings and extra hours produces busy days and a sincere belief that the practice is being looked after. You now have proof that you worked. That makes it harder to see the real issue than it was at the start.

It multiplies whatever the practice already is. If patients wait two hours because the doctor sees every case personally, a bigger waiting room does not fix that. It carries it forward, now with more chairs. A doctor who adds a second consulting room to a clinic where nobody can see the patient except him has not grown. He has made the same bottleneck more expensive.

By the time the real diagnosis arrives, it must be acted on with less money, argued against an investment you already made, and explained to a family who believes the problem is solved.

The Most Expensive Error in Practice

The greatest danger in your career is not one wrong prescription. Your training guards against that every day.

It is solving the right problem perfectly in the wrong practice.

You can be an excellent clinician and still build a practice that slowly fails, if you were solving the wrong problem.

You can work longer hours, buy better equipment and learn new procedures, and still make no real progress, because your effort is going to symptoms instead of causes.

This error hides inside competence. Skill cannot find it, because skill is not the missing ingredient. Better medicine cannot find it, because the medicine is already good. It survives every year, because patients ask *is the doctor good?* and rarely *is this practice built on the right decision?*

Before asking *how do I get more patients?*, ask:

What is really creating this problem?

And before asking *should I resign, buy the machine, sign the contract or take the partner?*, ask the same question about yourself.

This question changes everything.

Every Serious Profession Knows This

Think about any profession where mistakes are expensive.

You diagnose before you prescribe. An engineer finds the fault before replacing parts. A detective gathers evidence before naming a suspect. An architect studies the land before drawing the plan. A good lawyer reads the full file before advising a client.

In every discipline, understanding comes before action.

Your own practice should be no different. You already know this in the consulting room. You take a history and examine before you treat.

Yet many doctors reverse the order in their own decisions.

They act first. They understand later.

Not because they are careless. Because of pressure. The OPD is full. The equipment offer expires on Friday. The hospital wants the contract signed this week. Diagnosis has nothing to show for itself at ten at night after the last patient.

What This Book Will Not Do

It will not tell you whether to open a clinic, which machine to buy or which hospital to join. It cannot. Nobody who has not seen your town, your patients and your accounts can.

It will not give you medical advice. Nothing here is about how to diagnose or treat a patient. Clinical decisions belong to your training, your guidelines and your judgement. This book is about the decisions around your practice.

It will not give you legal, tax or regulatory advice either. Where a decision turns on medical council rules, clinical establishment registration, a contract, a loan or tax, read the current rules and consult a qualified adviser. This book helps you decide how to act once you know what the rules say.

And it will not save you time in the first week. It will cost you time in the first week, and return that time many times over in the months after. That is the same deal your own ten minutes of history-taking offers a patient.

What it will do is stop you from working brilliantly in the wrong direction.

♦ ♦ ♦

Because activity is not a strategy. Longer OPD hours are not a strategy. More pamphlets are not a strategy.

A real practice strategy begins with understanding what is actually happening in your practice and your career.

Every practice has many problems. Only a few decide what happens next.

Your first job is not to fix all of them.

It is to find out which one must be fixed first.

That raises an uncomfortable question, and the next chapter has to answer it.

If diagnosis matters this much, and doctors are trained, careful and honest, why is it so often wrong about their own practice?