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ART OF DRIVING CONSUMER ACTION

CONFIDENTIAL CASE STUDY

HEALTHCARE · BRAND & PERFORMANCE STRATEGY

From visibility without control to growth with control.

Rebuilding control, perception, and profitability for a senior orthopaedic leader in Delhi.

Client: A 250+ bedded hospital, Department of Orthopaedics (confidential) · Discipline: Joint Replacement · Shoulder · Arthroscopy · Engagement: Brand Control · PI & PBMS · Service-Line Strategy

CONTENTS

What's inside

01 · EXECUTIVE SUMMARY

The one-page version

A respected surgeon had demand, credibility, and footfall. What he didn't have was control — and without control, reputation wasn't converting into value.

This engagement involved the Department of Orthopaedics at a 250+ bedded hospital in Delhi, led by a senior orthopaedic surgeon recognised for joint replacement, shoulder surgery, and arthroscopy. The problem was not weak clinical acceptance. Patient inflow already existed and the surgeon's credibility was established.

The real issue was structural: strong inflow was not translating into **control, protected perception, or optimised profitability**. The doctor's reputation was working harder than the system around the doctor — creating operational leakage, brand dilution, and limited financial upside.

Our work re-established brand control, built a dedicated Patient Interaction (PI) and Brand Team, implemented a Performance-Based Management System (PBMS), shifted the patient journey from hospital-led to surgeon-led, upgraded the case mix toward high-value planned procedures, and strengthened intelligent digital acquisition.

90%+	150%	150
PATIENT-TO-SURGERY CONVERSION	PROFIT-MARGIN IMPROVEMENT	SURGERIES IN A SINGLE MONTH (PEAK)

Profitability moved from under 12% to a 150% improvement. Patient engagement grew 28% in the first 3 months and 40–45% across Year 1.

02 · CASE CONTEXT

A strong surgeon inside a weak system

The Department of Orthopaedics sat within a 250+ bedded Delhi hospital and was led by a senior surgeon with genuine standing in joint replacement, shoulder surgery, and arthroscopy.

What was already working

- Patient inflow already existed — demand was not the problem.
- The surgeon had established clinical credibility and trust.
- The department had enough visibility to attract patients on its own.

What wasn't

Despite all of the above, the strong inflow was not converting into structured control, protected perception, or healthy profitability. In effect, the surgeon's personal reputation was carrying the entire system — and the system was not carrying its weight in return.

> **The imbalance in one line**
>
> The doctor's brand had acceptance, but the flow around that brand stayed vulnerable to inconsistent handling, weak engagement continuity, and institutional structures that protected neither perception nor commercial value.

03 · THE SIX CORE CHALLENGES

Busy, but not in control

The case material points to six interlocking challenges. None of them was about visibility — and that was precisely the point.

1. **Strong inflow, poor OPD/IPD management**
   Patients were arriving, but the systems to handle and route them were weak.
2. **High bounce rate despite heavy footfall**
   Plenty of footfall, but too many patients dropped off before converting.
3. **Negative perception around the surgeon experience**
   The experience around the doctor wasn't matching the doctor's own reputation.
4. **Revenue skewed toward the hospital**
   The commercial structure favoured the institution over the surgeon's brand.
5. **Surgeon operating at limited financial upside**
   High effort and reputation, but constrained returns.
6. **Gradual dilution of personal brand value**
   Without protection, the surgeon's hard-won brand equity was slowly eroding.

04 · STRATEGIC READING — THE REAL PROBLEM

Not a visibility problem. A control problem.

Taken together, the six challenges revealed that this was never a marketing or awareness issue. It was a combined problem of **control, conversion, patient handling, brand ownership, and commercial structure**.

The diagnosis

Patient demand existed, but the patient journey was not sufficiently surgeon-centric. The doctor's brand had acceptance — yet the flow around it remained vulnerable at every step where the experience wasn't aligned to the surgeon's authority.

Where value leaks

When patient queries, documentation support, follow-up, pre-surgery reassurance, and post-process engagement aren't aligned, a surgeon's perceived value dilutes — even while clinical trust stays high. Reputation attracts; the system either converts that reputation into value, or quietly loses it.

> **"A senior doctor's reputation can generate demand. Without control, that demand never fully converts into value."**

05 · THE 30-DAY DIAGNOSTIC

We studied the journey before we touched it

Before prescribing anything, we ran a 30-day study of the actual patient journey. The reading was clear and practical: patients could reach the doctor, but the journey *after* that connection was not cohesive.

What the diagnostic revealed

- Reaching the surgeon was not the bottleneck — what happened next was.
- Handling, continuity, and reassurance were inconsistent across touchpoints.
- Internal branding was near-zero: the brand voice wasn't cohesive enough to protect the surgeon's value beyond direct doctor contact.

> **Why a diagnostic first**
>
> In healthcare, the gap between intent and conversion hides in the journey, not the headline. A 30-day observation surfaced exactly where trust was being built — and where it was leaking — so every later intervention was aimed at a real, located problem.

> **"We don't start with what to fix. We start with what's actually happening."**

06

The Core Insight

The surgeon's authority was the strongest trust anchor in the system — yet the patient journey wasn't organised around it. Rebuild the journey around the doctor, and control, conversion, and profitability follow.

07 · STRATEGIC APPROACH — OVERVIEW

A structured sequence, not scattered fixes

The approach evolved as a deliberate sequence. Each intervention stabilised the system enough to make the next one effective — front-end first, then mid-journey, then acquisition, then expansion.

#	INTERVENTION	PURPOSE
1	Brand Control Re-establishment	Make the journey surgeon-led, not hospital-led
2	PI & Brand Team	A human interface that speaks the surgeon's brand
3	PBMS Implementation	Structure, predictability, measurement
4	Call Routing & Flow Shift	A controlled, brand-first entry point
5	Clinic-Centric Experience	Trust and bonding before admission
6	Intelligent Digital Integration	Acquisition on a stabilised conversion base

Followed by internal branding and training, patient-led trust transfer, a case-mix upgrade, and finally strategic expansion into an independent setup.

08 · INTERVENTION 1

Brand control re-establishment

Shift the model from a hospital-led patient journey to a surgeon-led one.

The surgeon's authority was the strongest trust anchor in the system — yet the journey wasn't organised around it. So the first principle was to reorganise the entire flow around the surgeon's credibility.

What this meant in practice

The patient should not experience the doctor as merely one touchpoint inside a larger institutional maze. Instead, the journey had to feel consistent, directed, and aligned with the surgeon's own credibility — from the very first contact.

> **Why control comes first**
>
> Every later system — PI, PBMS, digital — only compounds value if it sits on a journey the surgeon's brand actually owns. Without that foundation, you optimise a flow that leaks at the source.

09 · INTERVENTION 2

The PI & Brand Team

Within approximately six months, we created a dedicated Patient Interaction (PI) and Brand Team — substantially established within the first 90 days.

Not an administrative desk

The crucial distinction: the PI layer was not a query-handling desk. It was designed as the **first lived expression of the surgeon's brand**. If the doctor represents authority, reassurance, and clarity, the first human interface around the doctor has to sound and act in the same language.

How the team was trained

- Brand communication — speaking in the surgeon's voice
- Empathy — reassurance as a clinical-grade skill
- Conversion discipline — guiding intent into committed decisions

> **Early impact**
>
> Establishing the PI module within 90 days created a smoother query-handling and conversion-management system that brought patient bounce under far better control.

10 · INTERVENTION 3

PBMS — Performance-Based Management System

PBMS is a complete framework that aligns teams, communication, and data to create predictable, measurable healthcare growth.

What it did here

PBMS structured patient flow, communication, and engagement tracking. Instead of letting growth depend on scattered effort, the system brought discipline into how patients entered, moved through, and were measured across the journey.

> **From effort to system**
>
> Reputation-driven growth is fragile because it depends on heroics. PBMS converted that into a repeatable system — the difference between a department that's busy and one that's predictably, measurably growing.

The three things PBMS aligned

- **Teams** — everyone working to the same defined standard
- **Communication** — consistent, brand-aligned messaging at every step
- **Data** — engagement and conversion made visible and trackable

11 · INTERVENTION 4

Call routing & flow shift

A particularly important move was redirecting OPD calls to the surgeon's clinic — establishing a controlled, brand-first patient entry point and reducing dependence on a hospital-led communication model that had been weakening continuity.

Why this was strategically powerful

It moved the first layer of trust formation closer to the surgeon's own brand environment. That improved clarity, raised response quality, and reduced the gap between patient intent and patient guidance.

> **The principle**
> The earliest moment of contact is where perception is set. Owning that moment — rather than leaving it to a generic institutional channel — means the surgeon's brand shapes the relationship from the first ring.

> **"Whoever owns the first conversation owns the patient's perception."**

12 · INTERVENTION 5

Clinic-centric experience design

The next stage strengthened patient trust and bonding *before* hospital admission, through a clinic-centric experience model. The intent wasn't operational convenience — it was to improve perception, satisfaction, and conversion by ensuring patients felt held and reassured before deeper treatment decisions.

Why this matters in orthopaedics

For planned procedures, the patient typically needs more than one consultation touchpoint, more than one reassurance moment, and more than one round of family-level confidence before committing. So the clinic became a **trust-design environment**, not just a consultation venue.

> **The reframing**
>
> A consultation room asks "what's wrong?" A trust-design environment asks "what will help this patient and their family feel confident enough to say yes?" That shift is what moved hesitation toward commitment.

13 · INTERVENTION 6

Intelligent digital integration

Once the front-end and mid-journey systems were under control, digital integration was strengthened to increase new patient acquisition through structured systems — because digital growth works best when the conversion architecture behind it is already stable.

Intention-led, not generic

Content and backend visibility were shaped after data mining and geo-tag understanding, so communication responded to what patients in the desired geographies were actually searching for. That made digital activity intention-led rather than generic broadcast.

> **Sequence is strategy**
> Most players pour money into digital acquisition first. We did it last — deliberately. Driving traffic into a leaky journey wastes spend. Stabilise conversion, then scale acquisition into it.

> **"Acquisition is only as good as the journey you send it into."**

14 · INTERNAL BRANDING & TRAINING

Closing the near-zero internal-branding gap

The early reading repeatedly pointed to one root cause: near-zero effective internal branding. The brand voice wasn't cohesive enough to protect the surgeon's value beyond direct doctor contact.

What we did

We launched integrated internal-branding and training programmes over multiple months, so the PI module could function in sync with three things at once:

- The doctor's own communication style
- The brand voice
- The patient's expectations

> **Why internal branding is the hidden lever**
>
> A brand isn't what the doctor says in the consult room — it's what every person around the doctor reinforces, or undermines, at every other moment. Align the internal voice, and the surgeon's value is protected even when he isn't in the room.

15 · PATIENT-LED TRUST TRANSFER

The RAP Booster programme

After the PI base was created, we introduced a RAP Booster-style programme: successful post-surgery patients were connected with surgery-suggested patients. This shifted patient experience from a passive outcome into an **active trust-transfer mechanism**.

Why this works in orthopaedics

Patients often move toward surgery not only when the doctor is respected, but when fear, uncertainty, and hesitation reduce through relatable proof. Patient-to-patient reassurance becomes a powerful conversion-support layer — one no advertisement can replicate.

> **The mechanism**
>
> A surgeon's reassurance is credible. Another patient's lived experience is *relatable*. Together, they close the gap between "I trust the doctor" and "I'm ready to undergo the procedure."

> **"The most persuasive voice in the room is often another patient who's already been through it."**

16 · CASE-MIX UPGRADE STRATEGY

From volume to value

An advanced layer was the decision to reduce dependence on smaller surgeries — trauma, fracture, and fixation work — and increase the share of larger, planned procedures: TKR, THR, shoulder surgery, and arthroscopy. This was not a volume strategy. It was a **value and case-quality strategy**.

The obvious risk

If smaller cases reduce but larger planned procedures don't grow fast enough, total surgery numbers can fall. Managing that risk was the real challenge.

How the risk was managed

- Google backend interface work to capture high-intent demand
- A two-location OPD module to widen qualified reach
- Patient-engagement programming to sustain conversion
- Continued content support aligned to planned-procedure intent

> **The proof it worked**
>
> The system recently produced a high of **150 surgeries in a single month (April)** while pursuing this stronger planned-surgery mix — showing that higher-value service-line strategy did not come at the cost of throughput collapse.

17 · STRATEGIC EXPANSION

From department to independent setup

After the system stabilised over about one year and operational gaps were reduced, the programme moved toward strategic expansion. Patients were transitioned into a new independent setup, reflecting a more mature level of system control and brand ownership.

Why this stage matters

It shows the work was never limited to improving one department inside one hospital. It evolved into a model capable of supporting greater independence, better financial control, and stronger brand leverage for the surgeon.

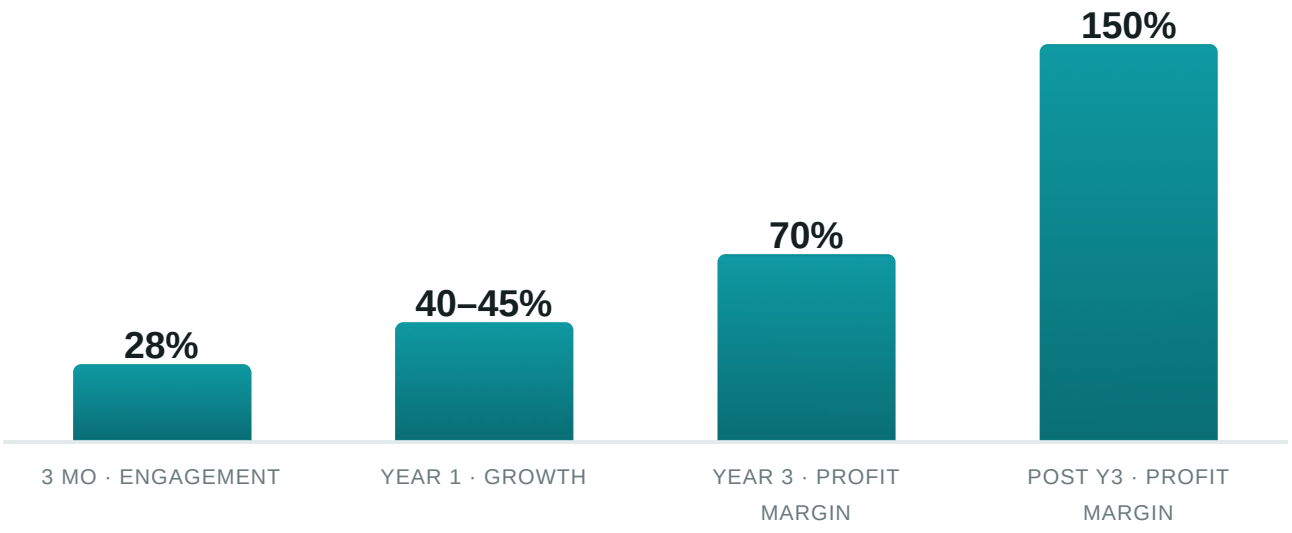
> **The arc of the engagement**
>
> Stabilise the journey → build the systems → upgrade the case mix → then graduate to independence. Each stage earned the right to the next. Expansion wasn't a leap; it was the natural result of control compounding over time.

18 · GROWTH TIMELINE & OUTCOMES

How the growth compounded

The phased reading shows growth building stage by stage as control deepened.

PHASE	KEY MILESTONE	GROWTH IMPACT
First 3 months	PI team and system setup	Patient engagement +28%
Year 1	Call routing & clinic control (vs hospital-led)	40–45% growth
Year 2	System optimisation	Higher surgical volumes
Year 3	Independent setup established	70% profit-margin improvement
Post Year 3	**Advanced PI + PBMS-driven branding**	**150% profit-margin improvement**



19 · BEFORE VS AFTER

The structural change, at a glance

METRIC	BEFORE	AFTER
Patient flow	High but unstructured	Controlled and optimised
Conversion rate	Low	Significantly improved (90%+)
Brand perception	Diluted	Strong and surgeon-centric
Revenue control	Hospital-driven	Surgeon-driven
Profitability	**Limited (under 12%)**	**150% increase**

This case is best understood as a shift from **visibility without control** to **growth with control**. The surgeon already had market credibility; what changed was the system around that credibility — built to protect conversion, perception, and profitability.

90%+
CONVERSION

150%
PROFITABILITY

Surgeon
-LED REVENUE & BRAND

20 · STRATEGIC TAKEAWAYS

What this case teaches

1. **Reputation generates demand; only control converts it**
   A senior doctor's name brings patients in. Without journey control, that demand never becomes value.

2. **The first human interface is the brand**
   The PI team wasn't admin — it was the surgeon's brand, lived at the first point of contact.

3. **Stabilise conversion before scaling acquisition**
   Digital was strengthened last, on purpose. Traffic into a leaky journey is wasted spend.

4. **Value beats volume — if you manage the transition**
   Upgrading the case mix toward planned procedures raised margins without collapsing throughput.

5. **Internal branding protects external value**
   Near-zero internal brand cohesion was the hidden leak. Closing it protected the surgeon's equity.

> **"A specialty department can move from merely busy to strategically profitable — when control, cohesion, and systems come together."**

21 · HOW OCEAN WORKS

Strategy at the core. 360° in execution.

This engagement reflects how we work on every brief: diagnose the real problem, build systems on evidence, and carry the work through to measurable results.

R **Review**
Existing perception, positioning, and the gaps that leak value.

R **Research**
Behaviour, journey diagnostics, competitive and geo insights.

R **Renew**
Clear positioning, systems, and communication direction.

R **Roll-Out**
Coordinated execution, tracked and optimised over time.

Why clients stay

Founder-led thinking, a multi-sector lens that reveals patterns single-sector agencies miss, and an obsession with outcomes over output. We don't sell projects — we build partnerships that compound, with 8+ years of average client retention.

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Busy isn't the same as profitable. Let's fix the gap.

If your demand is strong but your systems aren't converting it into value, we should talk. We build the control, cohesion, and performance systems that turn reputation into results.

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