Private intensive care units in Mumbai

A survey of 'intensive care units'in Mumbai reveals some shocking facts

Herat R Parmar

The plight of patients admitted into private ICU-ICCU hospitals in the city of Mumbai is pathetic. This fact provided reason enough to study the subject. An examination of the conditions of these specialist units demonstrates that they violate the most fundamental human right - the right to life - and the directive principle of the right to health care. The phenomenal mushrooming of these private ICU- and ICCU-hospi tals in Mumbai parallels the commercialisation of the medical profession and is fast destroying its ethics and morals.

Of** 40 **hospitals, only a small number had the following important equipment:

Central monitor	21
Ventilator/ respirator	12
Central oxygen	08
Pacing	16
Pulse oximeter	10
2-D echocardiography	10
Infusion pump	03
Holter monitor	02
Generator	23
Fire extinguisher	03
Image intensifier (fluorescent)	00
Central suction	03
Arterial blood gas analyser	00

T'nere are no standards or regulatory bodies for private nursing homes, or to the private ICCUs which cater to almost 85 per cent of the city's population.

The terms 'intensive care unit' and 'intensive cardiac care unit' conjure up a picture of a struggle to survive; the most vulnerable and unfortunate of humans, in need of the utmost care.

Critical care is a high-technology specialisation in medicine. People admitted are often dangerously ill on admission. They can also be high-risk cases — ill and with associated medical problems — stable but admitted for observation because they could develop a life-threatening situation at any time. Proper critical care with timely diagnosis can save their lives. This second category benefits most from proper and scientific critical care.

There are four categories of ICU-ICCU hospitals: government and municipal which are free, subsidised charitable trust hospitals; private trust and corporate hospitals, and totally private single or partnership ventures. This study examined 40 ICU-ICCU hospitals in the last category.

Medical nursing homes in Mumbai tend to label a few beds 'critical care beds' and proclaim themselves to be an ICU-ICCU hospital. The only uniformity one could note in these units was **a big hoarding; 50-70** square feet for each bed and the attached gadgets; an ECG machine; **a cardiac monitor (in slightly over half of the units surveyed);** a defibrillator, a suction machine, oxygen cylinders, an ambu bag with tubes, and some injections. **The RMO was often non-allopathic, the nurse often unqualified, and a qualified specialist was rarely present at the time of the visit.**

Critical care requires the presence of a team of qualified specialists on the premises round the clock, and of a knowledgeable director who coordinates the team of specialists managing the case.

However, in the private critical care hospitals visited, it was found that relatives were asked to observe the cardiac monitor and alert changes in cardiac rhythm to the sleeping RMOs and nurses. They were also asked to provide nursing care such as sponging, feeding, making beds, giving medicines, and giving bed pans.

The 40 ICUs-ICCUs visited (all were in the suburbs) admitted cases referred by family physicians and specialists as well as by doctors who may have a stake in the unit. Patients also came directly for emergency admissions.

The doctor on duty was rarely an allopath. Round-the-clock critical care, monitoring, and assessment of the progress or deterioration of the patient were all left to a non-allopathic doctor on duty, and to

Of** 40 **hospitals, only a small number offered the following procedures:

Central venous lines	04
Swan Ganz catheter	00
Total parenteral nutrition	00
Invasive arterial blood pressure monitoring	00
Endotracheal intubation	**36**
Tracheotomy	16
Intercostal drainage	30
Intracranial pressure monitoring	00
Bedside cardiac pacing	**16**
Ventilatory support	07
Bedside bronchoscopy	00
Bedside dialysis	00

However, even if these facilities were available, doctors were not always present to perform the procedure.

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unqualified nurses.The specialists were rarely in the hospital, often choosing to order treatment by telephone.

Other facilities on the premises: Number of hospitals out of 40	
Drugs for routine use	22
Drugs for emergency use	15
Streptokinase	08
t-PA	00
Nitroglycerine	08
Heparin	08
Laboratory for routine tests special tests and enzymes	02
Resuscitation equipment and drugs on trolley properly checked	02
Blood bank	01

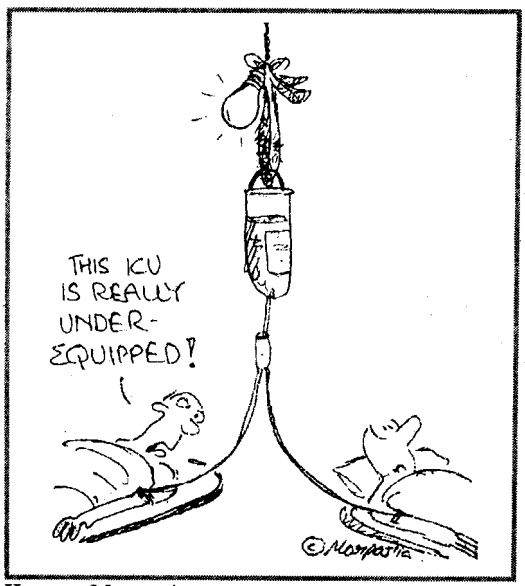
Charges varied from Rs 600 to Rs 1,500 per day for a cot and use of the cardiac monitor. All 40 hospitals surveyed offered a raeferral commission ranging from 30 per cent to 60 per cent. This would result in compromised services, unwarranted admissions and treatment, and even death.

In terms of the hospitals' functioning, there was no evidence of standard protocol for critical care; no teamwork amongst the treating specialists; no holistic approach; no mortality auditing; no evidence that the doctors kept themselves up to date on medical developments. The absence of essential drugs such as injectable streptokinase and nitroglycerine is deplorable.

Patients' relatives evidently accept as destiny the unnecessary deaths that must occur from such negligent treatment. They are helpless, the laws outdated, litigation prolonged and expensive, and there is no other system to redress their grievances. Nor is support of any kind forthcoming: not from the medical community, not from defunct medical councils which protect the professsion, not from apathetic governments, municipal corporations, medical associations which include the Indian Society of Critical Care. This apathy and lack of support at all levels will certainly have contributed to the shoddy functioning of these so-called 'critical care units'.

Apparently it is impossible to run a critical care unit with minimum standards. The purpose of a critical care unit is to save lives. However, this does not happen in these units. When you call an ICU-ICCU hospital, it should give that care. Precious lives should not be extinguished because you advertise something that you don't give.

(Based on a thesis in the department of civics and politics, University of Mumbai)



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Suggested readings :

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2. Rawliss M.D.: Doctorsand the drug makers. *Lancer 1984; 8397:* 276 – 270.

3. Chern M.M., Landefeld S, Murray T.H. Doctors, drug companies and gifts. *JAMA 1989;* 262, 24: 3443 -

Prohibition

Misguidedly advocated and enforced
Merely spawned the hydra-headed mafia
That continues to terrorise and spread
Its tentacles here and abroad.

Dubai, Pakistan, Singapore and Malaysia
Are merely some of the havens
Where these gangsters dwell,
Commanding willing stars
From Bollywood or the world of cricket.

What can we, doctors, do?
Educate,
And, best of all.
Serve as examples
Of rectitude.

P.
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Call for manuscripts

An editorial in the BMJ calls for manuscripts for its November 1999 issue which will be devoted to the impact of new technologies in medicine.

While highlighting some ways technology may improve patients' lives — microsurgery, informatics, transplantation, gene therapy, and dialysis — it will also debate ethical issues such as the changing doctor-patient relationship under the influence of the world wide web, the ethics of keeping "expensive" patients alive, whether new technology is simply increasing the gap between the haves and have-nots, and how to regulate the global explosion of new technologies.

Reports of original research, educational articles, debate pieces, and rigorous review articles looking at the impact of new technology in its widest sense will be examined by an international panel of experts. All manuscripts will go through the usual peer review process, and the deadline for submission is May 1, 1999.