LETTER

Intensive care unit guidelines for admission and discharge, 2023.

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The Directorate General of Health Services (DGHS), India, has released guidelines for intensive care unit (ICU) admission and discharge [1] to guide intensivists and registered medical practitioners (RMPs) in an Expert Consensus Statement (ECS). This is based on the recommendations of 24 experts working in different ICU settings. This team deserves applause for their efforts in creating guidelines for clinicians working in ICU settings. The Delphi method [2], considered one of the most scientific methods for such statements, has been used for this ECS.

The authors have stated that critical care, intensive care, and intensive therapy are synonymous, probably with the intention that different terms used by different practitioners should not lead to confusion. However, this may create problems — for persons with mental disorders requiring intensive care — from the perspective of medical insurance coverage. Following the enactment of the Mental Health Care Act (MHCA) 2017 [3], the Insurance Regulatory and Development Authority of India (IRDAI) has mandated that all insurance companies should cover treatments for mental disorders on par with those for physical illness [4]. Such coverage includes admission to ICU or High Dependency Units (HDU) for acutely agitated or disturbed persons with mental illness (PMI), including substance use disorders, posing increased risks to themselves or others.

A closer examination of seven admission criteria listed in this ECS suggests that, while creating this document, health has been viewed from a physical perspective only, as there is no mention of any need for admission of PMI requiring admission in an ICU or HDU.

The statement, under point three, conveys that if a patient refuses to be admitted to the ICU, such a patient should not be admitted to the ICU. It is possible that PMIs with suicidal intent, persons with delirium tremens, or those with substance use disorders, including intoxication, may refuse ICU admission. In all such cases, clinicians should make decisions aligning with the MHCA 2017 and the patient's best interests. Inclusion of a statement that "intensivists or RMPs should decide upon the need for admission of patients in ICU settings based on the best interests of the patient and should consider medico-legal opinion when in doubt" would have been more apt.

Stand-alone psychiatric hospitals are likely to have critical care or ICU or intensive therapy units to address the needs of agitated persons whose behavioural or physiological disturbances may be related to underlying mental disorders, medical disorders, or substance use-related problems. It is also not uncommon to find admission of persons with alcohol withdrawal delirium or persons acutely agitated with a possible psychosis in regular medical intensive care units in small towns, where there is no access to nearby psychiatric care facilities. Therefore, any ICU admission guidelines should be from a complete health perspective, including both physical and mental health.

The lack of foreword and context for this ECS poses a danger to the utilisation of this document in a court of law against RMPs who might have admitted or discharged PMI from the ICU based on their clinical judgement, besides posing challenges to insurance coverage for PMI admitted in ICU settings as part of their mental illness treatment. The inclusion of background for the creation of the ECS, limitations in its scope, acknowledgement of the complexities involved in real-life admission and discharge of acutely ill patients, particularly of the mentally ill in ICU settings, and the provision of any evidence for backing the Statement, if included, could have made this ECS more relatable and valuable. Studying the "ICU Admission Guidelines" issued by the National Health Trust [5] United Kingdom, and "Guidelines for ICU Admission, Discharge, and Triage" [6] by the American College of Critical Care Medicine could be useful in this regard.

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