CURRENT STATUS OF CRITICAL CARE MEDICINE IN INDIA

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Introduction

• Critical care started formally in India during late 1960s with respiratory care and intensive cardiac care.
• Later, super-specialities like NICU, PICU, Neuro ICU, etc. developed.
• ISCCM formed in 1993.
• Kolkata chapter of ISCCM in 1996.
• Now ISCCM has 60 branches & 5000 members
Present state of critical care in India
National policies and guidelines

• National policies and guidelines formed for
  – organizing CCUs (level 1, level 2 and level 3)
  – infection control in CCUs
  – transport of critically ill patients
  – end of life care etc.
Patients treated in CCUs

• Polytrauma, Pancreatitis, Sepsis, Myocardial Infarction, Endocrine Emergencies, etc.

• Additionally, endemic crises from tropical diseases like Dengue, Malaria, Plague, etc.
Need for enhancing human resources

- India being a **high demand low supply country**, the model to succeed here in critical care is to enable through avalanche method, physicians, paramedics and critical care technicians.
Training programs in critical care

- Diploma (IDCCM) & Fellowship (IFCCM) in Critical Care Medicine introduced.
- National Board of Examinations, New Delhi, established a post-doctoral fellowship in critical care at 10 centers.
- A DM in Intensive Care by Ramachandra Medical College in Chennai
- Course in Pulmonary and Critical Care Medicine by the Post Graduate Institute, Chandigarh.
- Numerous other courses like FCCS, ACLS etc.
Awareness program in schools

• Basic life support introduced in school curriculum in West Bengal with close involvement of some ISCCM members.
Awareness programs in critical care

• Conducted special camps and trainings for general public and other organizations in Basic Life Support, Primary management during accident when there is no doctor.

• Of notable mention is the success in training West Bengal Police and Kolkata police in CPR who now have become independent in training their own personnel.

• Being a large force on the ground, they are reaching many people daily.
PRO-PEOPLE ACTIVITIES OF ISCCM

BASIC LIFE SUPPORT TRAINING

Discussion with Calcutta Fire Brigade Officials in a training programme on CPR and Primary Management of Accident When there is no Doctor.

Dr. Kole demonstrating CPR to Commissioner of Calcutta police (1997)

CPR training in Schools
Critical care in disasters

• Disaster preparedness integral to ICUs, both inside and outside.
• As a first chairman of Disaster Management Committee of ISCCM the onus was on us to contribute with our expertise as much as possible to the disaster victims in all the major disasters in and around India.
PRO-PEOPLE ACTIVITIES OF ISCCM

Disaster Preparedness Programme with Kolkata Police Fire Brigade, NGOs, Ramkrishna Mission Hospital, UNICEF & Military Personnel at Kolkata (2001)
Certificate of Appreciation

The Department of Health warmly appreciates the following member of delegation for the participation in medical emergency management in the regions affected by the Cyclone Nargis, in Myanmar.

Name: DR. SAURABH KOLE
Group of Delegation: Indian Medical Team
Place of Activities: Dala Township

Date: 28th June 2008

Dr. Win Myint
Deputy Director General
Department of Health
Ministry of Health
Myanmar

Dr Saurabh Kole with team members at Dalaya Hospital, Mayanmar after Cyclone Nargis-2008
NEPAL EARTH QUAKE 2015

Meeting with President of Nepal while providing medical help
Need of more critical care - estimates

• About 100,000 ICU beds of all types available across the country.
• Cater to approximately eight million patients requiring ICU admission every year.
• It is not enough.
Rural Critical Care

• Surveys show that 68% of Indians live in rural areas ([data.worldbank.org](http://data.worldbank.org), 2013)
• Focus now on providing healthcare and critical care services to the rural India thus serving the masses.
• Strong initiatives in that direction have already started.
Rural Critical Care – Govt. initiative

• Personally involved in a West Bengal State Govt. initiative to launch CCUs and HDUs at primary, sub-divisional and district hospitals all across the state, available at a distance of 50 kms from both rural and urban areas.
Critical Care in a village
Comprehensive e-Critical care model

- Network of public healthcare facilities in rural India
- The sufficiency of budget allotted by government
- Healthcare Professional working rural healthcare
- The financial support for healthcare services
- Transportation facilities to reach hospital
- Level of computer penetration and proficiency
- Level of Internet penetration and proficiency
- Technological Issues faced in the area
Rural Healthcare System
1 Public Healthcare System
2 Private Healthcare System
3 Traditional Healers

Improvement in ICT Infrastructure
1 Computer
2 Internet
3 Computer Accessories
4 Telemedicine Equipments
5 Application Software’s
6 Operating Systems

Governmental Support
1 Ministry of Health
2 Ministry of Information Communication Technology
3 Ministry of Transport
4 Ministry of Energy

Purchase Better Medical Equipments
1 Donor Funding
2 Revenue from Hospitals
3 Funding from Ministry of Health

Train Personnel
1 Management
2 Doctors
3 Clinical Officers
4 Nurses

Improve Infrastructure
1 Transport system
2 Networking
3 Power supply
4 Hospital administration (staff, drugs, equipments, etc)

E-Healthcare System Services
An implementable model

- Systematic treatment of all related aspects makes this model implementable and valuable
- Advantages towards implementation
  - Strong govt. focus on rural development
  - Deep mobile penetration – low speed internet
  - Fast rise in high speed internet penetration
Conclusion

The coming decades will see -

- **Low cost preventive care** and **emergency care** to negate the spread of deadly viruses/diseases.
- Bridging the need gap in critical care especially in rural areas for serving the masses at low cost through continuing innovations and e-healthcare services.
Thank you